iSPS-US

THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS

UNITED STATES CHAPTER

ISPS-US 17th Annual Meeting

Life, Liberty and the Pursuit of Wholeness in Extreme States

November 9-11, 2018

Courtyard by Marriott Downtown
Philadelphia, PA

ABSTRACTS, TARGET AUDIENCE, LEARNING OBJECTIVES & REFERENCES

Abstracts are in chronological order.

Friday, November 9

Plenary: Paul Grant, PhD & Ellen Inverso, PsyD

Flourishing in the Community Through Recovery-Oriented Cognitive Therapy

Introductory

Recovery-oriented cognitive therapy (CT-R) is an empirically supported, collaborative approach for people diagnosed with “serious mental illness” that operationalizes recovery and resiliency in a person-centered, strength-based way. The approach applies across the range of severity, and includes: a) a way to understand the challenges (low energy, disorganization, grandiosity, hallucinations, aggression, self-injury, etc.) that can keep one from getting their desired life, and b) strategies for action to promote that life to its fullest. Individuals can go from feeling defeated to flourishing, from chronic institutionalization to life in the community. There is a successful integration of adaptive beliefs and confidence that enables individuals to thrive in the life of their choosing. The presentation will focus on theory and science supporting the model, the basic protocol, team-based approaches, as well as successful implementation in a large mental health system -- all producing significant culture change.

At the conclusion of this activity, participants should be able to:

1. Interpret evidence that supports the formulations of recovery-oriented cognitive therapy.
2. Identify ways that recovery dimensions (connection, hope, purpose) are operationalized.
3. Recognize features of culture change in hospitals and community behavioral health centers.

Grant, P. M., Bredemeier, K., & Beck, A. T. (2017). Six-Month Follow-Up of Recovery-Oriented Cognitive Therapy for Low-Functioning Individuals With Schizophrenia. Psychiatric Services, 68(10), 997-1002. doi:10.1176/appi.ps.201600413

Grant, P.M., Perivoliotis, D., Luther, L., Bredemeier, K., Beck, A.T. (2017). Rapid Improvement in Beliefs, Mood, and Performance Following an Experimental Success Experience in Low Functioning Schizophrenia. Psychological Medicine.

Grant, P.M., Reisweber, J., Luther, L., Brinen, A.P., Beck, A.T. (2014). Successfully Breaking a 20-Year Cycle of Hospitalizations with Recovery-Oriented Cognitive Therapy for Schizophrenia, Psychological Services, 11(2): 125-133.

Plenary: Irene Hurford, MD

Ethical Dilemmas in the Treatment of First Episode Psychosis

Introductory

Treatment of first episode psychosis (FEP) has been viewed as an opportunity to change the trajectory of the lives of those with psychosis experiences. Much of the treatments are psychological and focused on resiliency and recovery. However, for psychiatrists or other prescribers in this discipline, a more person-centered approach can lead to difficult ethical issues around autonomy and personhood vs. neglectful care, and how to best "do no harm". This conversation hour will be an opportunity for those who are interested to engage in a respectful and open discussion about how to navigate these challenging issues. All voices are welcome and will be heard.

At the conclusion of this activity, participants should be able to:

1. Discuss the ethical concerns around medication treatment of individuals in FEP.
2. Enumerate several meaningful pros and cons to coerced care.
3. Debate both sides of the issue in a respectful way.

Perceived Autonomy Support in the NIMH RAISE Early Treatment Program. Browne J, Penn DL, Bauer DJ, Meyer-Kalos P, Mueser KT, Robinson DG, Addington J, Schooler NR, Glynn SM, Gingerich S, Marcy P, Kane JM. Psychiatr Serv. 2017 Sep 1;68(9):916-922.

Treatment engagement of individuals experiencing mental illness: review and update. Dixon LB, Holoshitz Y, Nossel I. World Psychiatry. 2016 Feb;15(1):13-20

Changing perceptions of illness in the early course of psychosis: psychological pathways to self-determination and self-management of treatment. Gearing RE, DeVylder JE, Chen F, Pogge DL, Buccolo M. Psychiatry. 2014 Winter;77(4):344-59

Breakout Sessions

Jane Holloway, MA *"Under Cover of Camouflage": Racialized Identity and Psychotic Experience*

Introductory

This paper describes a case in which clinical enactments of antiblack racism are paradoxically both detrimental and crucial to a treatment in an institutional setting. Case material from individuals experiencing psychosis will be used to show the ways in which those cast as the racialized "other" find ways to wield power that both call into question and exceed the boundaries of the racial basis of power structures. The experience of racism as a traumatizing event is rendered visible in presentations of severe mental illness. There exists a relationship between dominant structures of power and internal psychic processes (Butler, 1997; Foucault, 1995; Foucault, 2000). This paper will describe the interlocking mechanisms of structural power and the subjective experience of the self, focusing on an analysis of race and psychosis that draws from critical race theory and psychoanalysis. In a discussion of psychotic material that deals explicitly with racial themes (e.g. skin color), I will use theorizations of whiteness in particular to identify why some nonwhite patients and specifically black patients, in the presence of their white clinicians, sometimes begin to describe themselves as white (Ahmed, 2007). Within psychoanalysis, Layton describes a neoliberal subjectivity that splits differences into cultural hierarchies (2010). A primary way in which such splits occur is through racialization, which is the legacy of the creation of race as a category devised to instrumentalize certain bodies as property (DuBois, 1994; Fanon, 2008; Fassin, 2011).

This paper considers whiteness as a dominant structure of power that is intertwined with different kinds of institutions, and psychiatric hospitals in particular. One question this paper seeks to address is: How might a politically-inflected understanding of delusions be important to someone's treatment and recovery?

The answer will be explored through an examination of the political structures that can be covertly found within individualistic forms of psychology (Yancy, 2008; Adams & Salter, 2011). Delusional ideas will be analyzed as an aberrant system of beliefs that works defensively to re-inscribe a subjectivity that

has been wounded (Carter, 2007; Walls, 2007; Seshadri-Crooks, 2002). I propose a countervailing conceptualization of intrapsychic experience that attempts to bridge the gap between individualistic psychological constructs and more structural understandings of the psychic pain of racialization.

At the conclusion of this activity, participants should be able to:
1. Identify the influence of white supremacy as it dominates the foundational understanding of psychotherapeutic care.
2. Formulate their own positionality within the dominant power structure of white supremacy as it specifically affects and inhibits therapeutic action.
3. Identify ways they can reinterpret and leverage their power within systems such as hospitals and community health settings to work more therapeutically.

Longden, E., & Read, J. (2016). Social Adversity in the Etiology of Psychosis: A Review of the Evidence. American Journal of Psychotherapy, 70(1), 5–33.

Sanati, A., & Kyratsous, M. (2015). Epistemic injustice in assessment of delusions. Journal of Evaluation in Clinical Practice, 21(3), 479–485. https://doi.org/10.1111/jep.12347

Yakushko, O., Miles, P., Rajan, I., Bujko, B., & Thomas, D. (2016). Cultural unconscious in research: integrating multicultural and depth paradigms in qualitative research. Journal of Analytical Psychology, 61(5), 656–675. https://doi.org/10.1111/1468-5922.12257

Basant Pradhan, MD & Narsimha R. Pinninti, MD *TIMBER Psychotherapy for Wellness, Traumatic Psychosis and Related Conditions: For Providers, Clients and Caregivers:* ***Parts 1 & 2***
You must attend both Part 1 and Part 2 of this workshop to receive credit for it.
Intermediate
Trauma is ubiquitous and causes variety of psychological symptoms including psychosis. Our current understanding of trauma and the pathways from trauma to psychosis is inadequate. As a result, existing psychological treatments are less than optimal in mitigating negative psychological experiences from trauma. A new conceptualization of traumatic memories that takes into account the central role they play in psychopathology is essential and informs a new mindfulness based treatment called TIMBER (trauma Interventions using mindfulness based extinction and reconsolidation). TIMBER also incorporates a wellness aspect that helps both providers and care givers to deal with traumatic stress associated with vicarious trauma can lead to the wellness aspect of TIMBER helps them to address stress associated with treatment of trauma.

At the conclusion of this activity, participants should be able to:
1. List the limitations in current understanding and treatment of trauma and related conditions such as traumatic psychosis.
2. Describe the wellness module of TIMBER that incorporates standardized techniques of Yoga and meditation for personal stress management and improving quality of life.
3. Demonstrate and list two skills from the TIMBER psychotherapy model that they can incorporate into their practice help clients self-manage symptoms of trauma, and related conditions such as traumatic psychosis.

Pinninti, N. R., Schmidt L, & Snyder R. Case Manager as Therapy Extender for Cognitive Behavior Therapy of Serious Mental Illness: A Case Report." Community Ment Health J 2014;50 : 4: 422-426

Brief Interventions for Psychosis: A Clinical Compendium
Editors: editors: Pradhan Basant, Pinninti Narsimha, Rathod Shanaya (2016). Springer. Switzerland.

Rathod, S., Kingdon, D., Pinninti, Narsimha, Turkington, D., Pheri, Peter (2015). Cultural Adaptation f CBT for Serious Mental Illness: A Guide for training and practice. West Sussex, Wiley Blackwell.

Schmidt, LT., Pinninti, N., R., Garfunkle, B., Solomon, P. Assertive community treatment. In editors. Yeager, K., et al. (2013). Modern community mental health. NY, Oxford.

John Thor Cornelius, MD & Charlotte Jevons, PsyD *Implications of Brief Reactive Psychosis: The Evaluation and Initial Engagement of Those in Need*
Advanced
The purpose of this presentation is to explore the initial engagement of those experiencing early onset psychoses in a way that will reconceive psychosis as informed by contemporary psychoanalytic, scientific, and dialogic perspectives. These perspectives make growing room for a plurality of etiologies regarding psychotic expression, such as the role of intersubjectivity, trauma, neurologic and existential perspectives regarding psychotic phenomenon. While certain expressions of psychotic material may carry prototypical themes (such as paranoia or grandiose elements), we will show how all these methods underscore the need to discern psychotic expression to the level of the individual in context of their individual, family and social network to help direct the course of initial engagement. The concept and implications of brief reactive forms of psychotic expression will be specifically explored and compared to more lasting expressions of psychotic material, thus emphasizing the need to be aware of various forms of psychoses to avoid inadvertent iatrogenic injury to the individuals we work with. We will propose a basic process of response that balances psychoanalytic, scientific and dialogic perspectives. This discussion will be supplemented by our own clinical experience in working with individuals and their families who experience an acute onset of psychotic phenomenon.

At the conclusion of this activity, participants should be able to:
1. Identify and describe brief reactive psychoses in comparison to other forms of psychoses.
2. Identify and explain the current tension between dialogic, psychoanalytic and pharmacologic forms of treatment for psychoses.
3. Explain and formulate the proposed response for working with individuals and their families with an acute onset of psychotic phenomenon.

Bergström, T., Alakare, B., Aaltonen, J., Mäki, P., Köngäs-Saviaro, P., Taskila, J. J., & Seikkula, J. (2017). The long-term use of psychiatric services within the Open Dialogue treatment system after first-episode psychosis. Psychosis,9(4), 310-321. doi:10.1080/17522439.2017.1344295

Bošnjak, D., Kekin, I., Hew, J., & Kuzman, M. R. (2016). Early interventions for prodromal stage of psychosis. Cochrane Database of Systematic Reviews. doi:10.1002/14651858.cd012236

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. Neuropsychiatry,4(1), 65-79. doi:10.2217/npy.13.89

Silver, A. S. (2013). Psychoanalytically Informed Treatment of Psychosis: Reflections on Its U.S. History and Current Dilemmas. The Psychoanalytic Review,100(2), 311-335. doi:10.1521/prev.2013.100.2.311

Zielasek, Z., Gaebel, W. (2015). Brief Reactive Psychoses. Bhugra, D., & Malhi, G. S. (Eds.) In Troublesome disguises: Managing challenging disorders in psychiatry.(pp. 27-43). Chichester, West Sussex: Wiley Blackwell.

Gillian Stephens Langdon, MA, MT-BC, LCAT, Mara Conan, PhD, Kristina Muenzenmaier, MD
Using Words and Music: Trauma Groups for People with Serious Mental Illness
Intermediate
This presentation will describe the music-verbal therapy trauma groups created in a public mental health facility. Based on the high prevalence of traumatic experiences in people with serious mental illness, we used interdisciplinary modalities in order to develop treatments for trauma survivors. A valuable mode of working emerged using a combination of verbal and music therapy. We will describe elements of music as tools in trauma treatment along with the use of words to identify specific problems and solutions. Examples will be shared from this interweaving of words and music as survivors identify

and create safety, begin to build healthy relationships, and maintain equilibrium while facing the challenges of their past traumatic experiences.

At the conclusion of this activity, participants should be able to:
1. Describe one aspect of the prevalence of stressful childhood experiences in survivors of serious mental illness.
2. Describe one advantage of combining music and verbal modalities for survivors of serious mental illness and stressful childhood experiences.
3. Give one example of what is needed to develop a successful co-leadership in a music-verbal therapy trauma group.

Langdon, G.S. Music Therapy for Adults With Mental Illness. In: Wheeler B. ed. Music Therapy Handbook. New York, NY: The Guilford Press: 2015.

Muenzenmaier K, Margolis F, Langdon GS, Rhodes D, Kobayashi T, Rifkin L. Transcending bias in diagnosis and treatment for women with serious mental illness. Women & Therapy. 2015: 38:141-155.

Muenzenmaier, K, Schneeberger A, Castille D, Battaglia J, Seixas A, Link, B. Stressful childhood experiences and clinical outcomes in people with serious mental illness: a gender comparison in a clinical psychiatric sample. Jrnl of Fam Viol. 2014: 29: 419,Äì429.

David Son, MS Ed, CPS & David L. Stark, MS, CPS
Peers as Peer Supporters/Peers as Professionals: Recovery as Liberation
Introductory
This panel looks at recovery from two different angles, first, within the broader social/professional framework of the mental health system, and then through an account of recovery as experience. In both accounts, the importance of peers as helpers and as witnesses to the process of healing are highlighted.

In *Pennsylvania: Peer Support Services: The "Friendly" Trojan Horse*, David Son speaks to the anxious place in which such services find themselves when embedded into the prevailing medical/disease model of mental health that is so prevalent in our institutions. The success of the consumer/survivor/ex-patient movement's advocacy for hope and recovery is attested to by so many individuals who successfully live, fully recover, from both deep distress and the effects of stigma, to live meaningful, purposeful lives. Yet while the mental health system acknowledges, affirms, "recovery principles," its gears are still greased - and are still powered by biomedical psychiatry at its core. This paper offers a call for well-intentioned fixing and/or meaningful overhaul, one that can liberate the peer worker/service user from unhealthy dissonance.

In *The Will To Recover: A Peer Professional's View*, David Stark likewise discusses the ways in which the recovery process can get mired in clashes of values, perspectives, and priorities. Yet he sees a path forward despite these obstacles. By developing the will to recover, we can hope to move beyond the senseless notion that recovery is too difficult to attain and should therefore be given up on. One way of sustaining our recoveries over the course of a lifetime is by working on our capacities to be willing agents in the service of our own recoveries. In exploring the role of the will, David will consider the confluence of the Windhorse approach and the Psychosynthesis tradition as it intersects in the lived experience of the peer professional.

At the conclusion of this activity, participants should be able to:
1. Examine barriers to positive outcomes of PSS, and recovery, within a biomedical psychiatric service system.
2. Discuss new frameworks - services and programs - to effect positive outcomes of PSS, and recovery.
3. Explain the centrality of the will in long-term recovery.
4. Discuss the role of the will in enduring and thriving as a peer professional.

Balter, M. (2017). Schizophrenia's Unyielding Mysteries. Scientific American, 316 (5):54-61.

Beavan, V., Jager, A. D., & Santos, B. D. (2017). Do peer-support groups for voice-hearers work? A small scale study of Hearing Voices Network support groups in Australia. Psychosis, 9 (1), 57-66.

Branitsky, A. (2017). Commentary: Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups. Frontiers in Psychology, 8.

CPS Grandparenting Application. (2018). Retrieved May 7, 2018, from https://www.pacertboard.org/certifications
A certification for mental health or co-occurring peer specialist

Hickey, P. (2018, May 07). "The Power Threat Meaning Framework": A New Perspective on Mental Distress. Retrieved May 7, 2018, from https://www.madinamerica.com/2018/05/power-threat-meaning-framework-new-perspective-on-mental-distress/

Longden, E., Read, J., & Dillon, J. (2016). Improving Community Mental Health Services: The Need for a Paradigm Shift. Israel Journal of Psychiatric Related Sciences, 53 (1), 22-30.

Longden, E., Read, J. & Dillon, J. (2018). Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups. Community Mental Health Journal, 54:184.

Marion, D. (2016, December 12). Bulletin, OMHSAS-16-12(United States, Department of Human Services, Office of Mental Health and Substance Abuse Services). Retrieved May 5, 2018, from http://www.dhs.pa.gov/publications/

SAMHSA - Substance Abuse and Mental Health Services Administration. (2018, April 25). Retrieved May 7, 2018, from http://www.samhsa.gov/
Trauma-informed care in behavioral health services, 2014

Styron, T, Utter, L, & Davidson, L. (2017). The hearing voices network: initial lessons and future directions for mental health professionals and Systems of Care. Psychiatric Quarterly, 88(4):769-785.

Archives of Psychiatric Nursing. "Finding Inspiration from the Philosophy of Maurice Merleau-Ponty for the Practice of Psychiatric-mental Health Nursing". Sandra P. Thomas, Nov. 2017.

Australasian Psychiatry. "A critical interpretive synthesis of the most commonly used self-report measures in Australian mental health research." Jennifer Bibb. 2016

Journal of Interprofessional Care. "A critical narrative analysis of shared decision-making in acute inpatient mental health care". Gemma Stacey. 2016

Journal of Military and Veteran's Health. "A commentary: Rethinking approaches to Resilience and Mental Health Training." M. Crane, D. Boga. 2017

Aaron T. Beck, MD & Ellen Inverso, PsyD *The Future of Transformative Care: A Lively Conversation with Drs. Aaron Beck and Ellen Inverso*

Introductory

A dialogue between Drs. Aaron T. Beck and Ellen Inverso on elements of Recovery-Oriented Cognitive Therapy (CT-R) and what Dr. Beck has had to learn - and unlearn - regarding treatment of individuals with psychosis over the last 20 years. They will also discuss how CT-R is aligned with the major tenants of the Enlightenment.

At the conclusion of this activity, participants should be able to:

1. Discuss the major shifts in psychiatric care for psychosis over the last several decades.
2. Summarize the overlap between CT-R and the tenants of the Enlightenment.
3. Describe the key principles of CT-R.

Beck, A., Himelstein, R., Bredemeier, K., Silverstein, S., & Grant, P. (2018). What accounts for poor functioning in people with schizophrenia: A re-evaluation of the contributions of neurocognitive v. attitudinal and motivational factors. Psychological Medicine, 1-10. doi:10.1017/S0033291718000442

Beck, A. T., Himelstein, R., & Grant, P. M. (2017). In and out of schizophrenia: Activation and deactivation of the negative and positive schemas. Schizophrenia Research. doi:10.1016/j.schres.2017.10.046

Thomas, E.C., Murakami-Brundage, J., Bertolami, N., Beck, A.T., Grant, P.M. (2018). Beck Self-Esteem Scale-Short Form: Development and psychometric evaluation of a scale for the assessment of self-concept in schizophrenia. Psychiatry Research, Volume 263, 173 - 180.

Martin A. Cosgro, PhD *Transitional States and the Threat of Annihilation: Working Toward Freedom Through Courage, Compassion and Persistence*

Intermediate

When working with people struggling with psychosis, transitional states can trigger underlying trauma which can lead to an increase in psychosis. However, if one is aware of the triggering mechanism and the underlying trauma that becomes activated, these can be opportunities for growth and progress in treatment as opposed to disheartening setbacks. Various common transitional states will be presented along with ways to help people deal more effectively with these often disabling stages in treatment.

At the conclusion of this activity, participants should be able to:

1. Identify at least 3 transitional states which can trigger an increase in psychosis.
2. Identify at least 2 traits that are helpful in traversing transitional states.
3. Identify at least 2 past traumas that may complicate experiencing transitional states.

Robinson, R., abd Gadd, D. - Annihilation Anxiety and Crime. Theoretical Criminology, Vol. 20 #2, 2016.

Winnicott, D. - Collected Papers: Through Pediatrics to Psychoanalysis. Tavistock Press. 2013.

Nutt, A. - The Terror of Annihilation. Presenting EPIS, Vol. 1, 2017.

Michael Selzer, MD *Unlocking the Therapist: The Role of Supervision in the Psychotherapy of Psychosis*

Intermediate

Many years ago, the Swedish government decided to offer schizophrenic individuals the opportunity for psychotherapy. Rather than initiating their program by focusing on the psychotherapy component, the national health service decided to first train a cadre of supervisors who would then train therapists. Based on my having run the schizophrenia division at Cornell for a decade, I was asked to develop the supervisory program. That experience made me keenly aware of the primary role supervision can play in the psychotherapy of schizophrenia, the subject of this paper. I explore the theoretical underpinnings

of supervision and illustrate them by clinical examples from both the therapist-supervisee and/ or the supervisor's perspective. The critical issue for the therapist is her difficulty recognizing any similarity between herself and her patient, the product of her fear that similarity equals sameness. Buttressing this distancing maneuver is the therapist's belief that nothing in either her training or life experience has prepared her for this encounter. She is without tools to bridge the gap. Ironically, when the therapist can recognize similarities between herself and her previously, "nothing like me" patient, she is then solidly able to appreciate their differences. Now secure that boundaries exist between them, the therapist can allow herself to experience the struggles of her patient as well as acknowledging aspects of that struggle which resonate within herself. The therapist's need for apartness is now replaced by a wish to engage more completely with her patient and herself. How supervision plays a key role in unlocking the therapist will be examined.

At the conclusion of this activity, participants should be able to:
1. Identify the key subjects to focus on in supervising psychotherapy of schizophrenic individuals.
2. As therapist, discuss the importance of identifying their fear of merging with their patients.
3. As supervisors, locate whenever their supervisee, in her interactions with her supervisor, reveals problems central to the treatment.

Bollas, C. Catch them before they fall. This psychoanalysis of breakdown. Routledge, N.Y. 2013.

The role of interpersonal connection, personal narrative, and metacognition in integrative psychotherapy for schizophrenia. Hamm J Journal of clinical psychology volume 72,pages 132 – 141, 2016.

With psychosis in mind–the reverberations of the psychotic encounter. Vincent DiRocco, Magalu Ravit, Psychoanalytic Psychotherapy 29, Pages 57 – 69, 2015.

Erin Soros, PhD *Where to Find Liberty*

Introductory

The title of my one-woman show—Where to Find Liberty--arises from a question I posed to strangers as I walked Vancouver's streets searching for the store, Liberty, where my sister worked. In this location I thought I would find my surprise wedding. Here would be everyone I loved, waiting for me to appear. It was both place and ideal, store and freedom. My delusion spoke of profound longing—for communication, recognition, connection. When I share my story publicly, I do not simply speak about madness, but rather through and in madness itself. I begin by making small slips in my sentences that the audience might read as errors in my speaking or in their listening—'wonder' instead of 'wander'; 'pubic' instead of 'public'—and then I play with these slips, homonym meeting homonym, sound echoing sound, until the audience rides with me on a surprising, disorienting journey as madness speaks what sanity cannot. My proposed presentation begins as a lecture then quickly becomes a piece of theater that unseats the audience's own sense of what is real and what is dream. We enter the terror of inhabiting a world where language does not hold. Here trauma and fantasy are psychically bound. What then is the expressive potential of madness? How exactly does trauma rupture linguistic utterance? Does shattered language cause insanity, or vice versa? Existing on the boundary between the creative and the critical, the sane and the insane, my presentation explores how reactive psychosis functions both as an escape from trauma and as a paradoxical form of testimony.

At the conclusion of this activity, participants should be able to:
1. Describe what an experience of psychosis feels like, specifically in relation to one's relationship with language.
2. Express empathy for someone experiencing psychosis.
3. Explain the relationship between trauma and madness--how madness can be a way to translate a traumatic experience and yet at other times a way to escape it.

2016. Bollas, Christopher. _When the Sun Bursts: The Enigma of Schizophrenia._ New Haven, Yale UP, 2016.

2016. Garrett, Michael. "Psychosis, Trauma, and Ordinary Mental Life," American journal of psychotherapy, Volume 70 , Issue 1 , p. 35

2015. Kirchner, Lewis. "Trauma and Psychosis: A Review and Framework for Psychoanalytic Understanding." _International Forum for Psychoanalysis_, Volume 24.

Saturday, November 10

Keynote Address: Berta Britz, CPS, MSW, ACSW

Practicing Revolution: Uniting to Do the Work of Love

Introductory

This talk invites us all to crack open our eyes, hearts and minds for liberty, locating being human as a dynamic process that everyone participates in co-creating. It is a call to de-colonize ourselves, to grow into our potential. It asks us to turn away from familiar approaches to difference that attempt to classify, cure, control, educate, normalize, manage, or punish in order to maintain a status quo that diminishes us all. It is a plea for communal courage.

My journey is lifelong. It is personal and political. I seek to cross borders. I seek fellow travelers. I don't seek an answer, but co-questioners. When I was young, I didn't have words to voice my questions. When I had words, acknowledging not knowing felt too dangerous. When my suffering was too intense, I sought answers from experts who didn't acknowledge their own fears and limited knowing.

This talk frames well-being in a social context. Labeling a person with a serious psychiatric diagnosis, reflects both the person being labeled and also the professional who uses authority to diagnose and recommend/order/provide treatment. The professional's worldview is a strong component in how they view the other, both in explicit and implicit judgments. Professionals who learn to practice cultural humility enable a person to become more visible, more intelligible, and easier for the professional to relate with. We've all been shaped by our experiences in learning and growing and often have not explored the limits of what we've learned, the consequences of accepting worldviews that can limit and harm others and ourselves.

We must stop perpetuating the harm caused by identifying human beings as "other," as objects requiring expert interventions. Civil rights disintegrate when they lack a communally-affirmed foundation of values. We reached this toxic place by failing to see ourselves in the other. When our vision is filtered through veils of fear, suffering, shame, guilt, blame, and anger, it is hard to see and treacherous to connect. To attain our full potential as mental health professionals, we need to not only use all our skills and training for the healing of others, but to join in a shared journey toward wholeness.

None of our questions or answers exist without light reflected from one another. We need to open our eyes, hearts, and minds in communal holding and curiosity. We must come together to create space that values, honors, and celebrates difference. This is the space from which wholeness and shared liberty emerge. We must dare to pour our aspirations, theories, and principles into the practice of love.

At the conclusion of this activity, participants should be able to:

1. Identify and describe the way in which at least two aspects of their professional or lived experience enhances their capacity to empathize with those who are different from them.
2. List two ways that their own experience has limited their ability to empathize with those who are different from them and identify two strategies for addressing those limitations.
3. Describe the impact on mental health services, society and people who serve and are served when civil and human rights are demanded and met.

Hakansson, C. (2014) The Extended Therapy Room, Coming from an Authentic Place…Jyvaskyla: University of Jyvaskyla.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

Speed, E., Moncrieff, J., Rapley, M., eds. (2014) De-medicalizing Misery II, Society, Politics, and the Mental Health Industry, New York, NY: Palgrave Macmillan.

Thomas, P., (2014) Psychiatry in Context: Experience, Meaning, and Communities, Monmouth, UK: PCCS Books.

Plenary: Casadi "Khaki" Marino, PhD, LCSW, Tami Michelle Gatta, MA, RDT, LCAT, CPS, Marty Hadge, Jennifer Hanley, DNP, F/PMHNP-BC, Michael Nelson, CPS
Experts by Experience Panel: Hope and Community
Introductory
First person accounts of extreme states of consciousness or madness are diverse and can be found in even classical antiquity. The published narrative of a mid-life psychosis by a prominent German citizen by the name of Daniel Schreber strongly influenced Freud as he was developing psychodynamic theory. Such memoirs as Elyn Saks' *The Center Cannot Hold* and Kay Redfield Jamison's *An Unquiet Mind* focus on the need to make meaning of experience, to maintain valued relationships and social roles, and to incorporate lived experience in valued identities. Individuals who have experienced extreme states of consciousness are vulnerable to internalizing negative societal messages and developing low self-regard and a sense of defeat. Peer support can build connection and empowerment and disclosure of lived experience can be especially powerful in developing valued identities. Recovery is beginning to be explored as an inherently social process. Social recovery is concerned not so much with recovering from illness but with recovering one's life. The members of the Experts by Experience panel will share from their lived experience of extreme states and peer and professional roles in order to address themes of hope, community, and liberation.

At the conclusion of this activity, participants should be able to:
1. Express empathy with the lived experience of extreme states of consciousness.
2. Explain the importance of making meaning of experience and developing a valued identity.
3. Define social recovery.

Buckley, P. (2014) Experiencing madness. American Journal of Psychotherapy, 68(3), 273-276.

Corrigan, P, Bink, A., Schmidt, A., Jones, N., & Rusch, N. (2016). What is the impact of self-stigma? Loss of self-respect and the "why try" effect. Journal of Mental Health, 25(1), 10-15.

Marino, C. (2015). To belong, contribute, and hope: First stage development of a measure of social recovery. Journal of Mental Health, 24(2), 68-72.

Breakout Sessions
Nancy Burke, PhD, Ann Green, Psych NP, Brian Koehler, PhD
The Therapeutic Relationship: An Essential Aspect of Psychotherapy
Intermediate
When, over a hundred years ago, Freud formulated his ideas about transference and countertransference, he brought attention to the so-called "doctor-patient relationship" when that aspect of treatment had been all but disregarded, and certainly not valued in any systematic way to that point. At the time, he was pessimistic about the usefulness of such dynamics when working with people experiencing psychosis, but others in his circle, and in the ensuing century, discovered otherwise. Today, we are profoundly aware that the relationship between therapist and person with lived experience is at the very center of healing, and are likewise cognizant of the fact that those who stand most to benefit from ongoing connections are the least likely to have access to them as they navigate our significantly broken mental health system. In this panel, we both celebrate the impact of relationships of effective concern in healing trauma and psychotic suffering and also provide a cautionary tale about the continued erosion of such treatment. We will explore the research relating not only to the social/emotional impact of the therapeutic relationships, but also to the impact of the therapeutic relationship on the psychobiology of each of the partners in a therapeutic dyad, and particularly upon the person with lived experience of psychosis. While we offer a perspective on the power of relationships, we will also discuss the erosion of respect for these relationships within the context of political, social, economic and ideological forces that have come together to threaten the widespread provision of healing connections. In conclusion, we will offer avenues for action, and will

encourage audience members to get involved in the fight to preserve psychotherapy for those who need it most.

At the conclusion of this activity, participants should be able to:
1. Describe the impact of the therapeutic relationship on the psychobiology of both partners in a therapeutic dyad.
2. Cite three current threats to the continued availability of relationship-based psychotherapy.
3. Describe the social/emotional impact of the therapeutic dyad.

Child Maltreatment and Clinical Outcome in Individuals at Ultra-High Risk for Psychosis in the EU-GEI High Risk Study. Tamar C Kraan; Eva Velthorst; Manouk Themmen; Lucia Valmaggia; Matthew J Kempton ...
Schizophrenia Bulletin, Volume 44, Issue 3, 6 April 2018, Pages 584–592

Clayson, J, (20 June 2017). The Future of Mental Health Therapy. On Point (WBUR, NPR, Boston). http://www.wbur.org/onpoint/2017/06/20/the-future-of-mental-health-therapy

Essig, T. (25 June 2015). Talkspace Argues With Talkspace: Conflicting Messages And Clinical Risk. https://www.forbes.com/sites/toddessig/2015/06/29/talkspace-argues-with-talkspace-conflicting-messages-and-clinical-risk/

J. Tyler Carpenter, PhD & Ronald Abramson, MD *Shifting Models of Care: Facts, Frameworks, and Choice Points for a Therapeutic Model of Psychosis*
Intermediate
Psychoanalytic derivatives are no longer prominent in the treatment of psychosis. As utilized, they offered limited help to those housed in stigmatizing, frequently iatrogenic environments. Timely developed pharmacological agents supported more humane, cost effective release of thousands into community-based treatment, forestalling gross chronicity. However, currently integrated treatments cannot be said to “cure” a disorder that mainstream psychiatry defines as “brain, not mind, diseases”. Our subjective sensations, impressions, thoughts, and feelings, are an aggregated reflection of consciousness, a fundamental property of the brain as it emerges in a biopsychosocial environmental context. Categorized as fundamental anomalies in related thought, emotion, interpersonal behavior, and identity, extreme states and their predisposing characteristics are defined as problems in adaptive function, seen through all of the human lenses of language, epistemology, and medical science. Brain changes that correlate with these states, do not directly cause these phenomena. Psychological therapies constitute a major dimension of therapeutic assistance for these patients. In the lens of research and clinical practice, these theories and related therapies comingle different dimensions known to have a recursive impact on adaptive function. Lately, there are positive reports of Avatar Therapy; and, self-help groups, such as The Hearing Voices Network.

This panel will consider the following realities:
Choices are not binary; and, the past is not prologue;
Language-thought co-creates a shared vision of the world; and, Brain-Mind are intimately entwined in ways that are both the same and not;
The Other is not only split off parts of our self, it is part of our individual and collective identity(ies)
Where are we, what do we know, and what don’t we know.
How do we integrate new data in evolving models; and, what are emergent bumps in the road.
What would an effective 4-wheel drive vehicle for the road ahead resemble.

At the conclusion of this activity, participants should be able to:
1. Identify at least 3 interdependent empirical facts relevant to the integrated psychological treatment of psychosis.
2. State how these interdependent facts might be joined in a psychological intervention.
3. Identify 3 potential obstacles in the development of a unified approach to psychological treatment.

Abramson R., The Trouble With Modern Psychiatry, New York, Lambert Academic Publishing, 2017.

Abramson R., "Psychotherapy of Psychoses – Some Principles for Practice in the Real World," Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry (now called "Psychodynamic Psychiatry"), 38: 485-502, 2010.

Koren, D., Klomek, A.D., Rothschild-Yakar, L., and Parnas, J. (2017) Attenuated Psychosis and Basic Self-Disturbance as Risk Factors for Depression and Suicidal Ideation/Behavior in Community-Dwelling Adolescents. Early Intervention in Psychiatry. November

Koren, D., Scheyer, R., Reznik, N., and Seidman, L. (2017). Basic self-disturbance, neurocognition and metacognition: A pilot study among help-seeking adolescents with and without attenuated psychosis syndrome. Early Intervention Psychiatry, October.

Stephensen, H., and Parnas, J. (2017). What can self-disorders in schizophrenia tell us about the nature of subjectivity? A psychopathological investigation. Phenomenology and Cognitive Science. September.

Oryx Cohen, MPA & Karen Blass, M.Ed. *Reducing Hospitalization by Using Emotional CPR in Communicating with People in Altered States*

Introductory

People who seem unreachable when they shift into altered states can be reached using Emotional CPR (eCPR) through emotional dialogue. Emotional CPR is a public health practice developed by people with lived experience that anybody can use to assist others through emotional crises. Ways of engaging in emotional dialogue will be demonstrated. Use of eCPR can reduce the over-reliance on hospitalization and medication, reinforcing an authentic, nonclinical response to emotional distress and altered states. The presenters will share their personal experiences with being in altered states (which are labeled psychosis) and helping others in those states. The presentation will include a demonstration of Emotional CPR as it applies to working with individuals experiencing altered states.

In traditional therapy, students are taught that you cannot communicate with someone when they are in altered states. Believing that people cannot be reached, professionals and families feel helpless and reflexively hospitalize and medicate the person in distress. We are learning verbal and nonverbal ways of communicating with persons in altered states that can reduce use of hospitalization and medication.

We urge the support person to refrain from questioning, labeling, advising, or getting caught up in the who, what, when of story. We call this emotional dialogue. These approaches involve unlearning traditional training, which emphasizes the verbal dimension while admonishing the sharing of one's own feelings. However, the eCPR way comes naturally and the eCPR "training" is often a reinforcement of our instincts. By teaching the eCPR way of communicating, every community resident can become a support to one and other and thereby build a more caring and respectful community.

At the conclusion of this activity, participants should be able to:

1. Explain the basics of the e, C, P, and R of Emotional CPR.
2. Describe the 6 intentions of Emotional CPR.
3. List at least 3 ways Emotional CPR can be used in working with people experiencing altered states.

Irina Georgieva Cornelis L Mulder and Richard Whittington. Evaluation of behavioral changes and subjective distress after exposure to coercive inpatient interventions. *BMC Psychiatry*2012**12**:54 https://doi.org/10.1186/1471-244X-12-54

Coral Muskett. Trauma-informed care in inpatient mental health settings: A review of the literature. International journal of mental health nursing, 2014 - Wiley Online Library. https://doi.org/10.1111/inm.12012

J.E. Hopkins, RN, BSN, S.J. Loeb, PhD, RN & D.M. Fick, PhD, RN, FGSA. Beyond Satisfaction, What service users expect of inpatient mental health care: A literature review. Journal of Psychiatric and Mental Health Nursing. First published: 05 November 2009
https://doi.org/10.1111/j.1365-2850.2009.01501.x

Emotional CPR Webinar: Saving Lives, Healing Communities (2013), https://www.emotional-cpr.org/videos-about-ecpr.htm

Spiro, L. (2013). eCPR (Emotional CPR): A Tool & a Process of Peacemaking, https://www.emotional-cpr.org/articles.htm

EMPOWER! Emotional CPR in Australia Pt. II (2018 radio show), http://www.unityradioma.org/empower
Emotional CPR (eCPR) Participant Workbook (2018), https://www.emotional-cpr.org/resources.htm

Elahe Hessamfar, PhD & Ron Unger, LCSW
Spirituality, Theology, and Psychosis: Finding Freedom in the Midst of Darkness
Introductory
This paper explores the spiritual dimension(s) of psychosis and considers freedom and liberation from madness through a theological lens. The spiritual is often a gap in our conversations, an area not enquired about.

Ron Unger's presentation will explore the deep existential and spiritual questions that people are likely to face after severe life difficulties and trauma. "Psychosis" can be understood as confused attempts to answer such questions, attempts that inadvertently lead to more problems.

Conventional approaches to treatment ignore not only the connection between trauma and psychosis, but also the legitimacy of the deeper, or spiritual, questions the trauma raises. If the problem is simply "illness" then such questions can be ignored by all involved! Except, the questions don't go away, and so typically, healing doesn't happen.

An alternative approach is to aim for a collaborative dialogue that gives legitimacy to important spiritual questions, and which frames a confused search for answers as of being of possible value, rather than as simply "sick." And by bringing balance and compassion to the search itself, relief may be found even when complete answers remain unavailable!

Elahe Hessamfar's paper attempts to address what constitutes freedom and liberation from madness through a theological lens. Is it sufficient to eliminate the symptoms? Is it acceptable to return to a functional life as previously held by the individual before the illness? Or does madness serve a far greater purpose?

The paper asserts that madness is transformative and the person coming out at the end is not the same as the person who entered it. That transformation is what constitutes true freedom and liberation that may have not been possible through any other means but the journey taken through darkness.

The key to freedom is to hear the voice of the illness, what the inner self is shouting out exposing the hidden longings of the human spirit. That inner journey can become torturous and dangerous, but the one who travels through it and comes out on the other side has experienced the truth of human condition. And Truth is the foundation for liberty.

At the conclusion of this activity, participants should be able to:
1. Map the way trauma raises spiritual questions, which can lead to both psychotic instability and to new discoveries or spiritual breakthroughs.

2. Balance respecting alternative views held by people with psychosis with helping people question rigidities in views that may be leading to trouble.
3. Assess the inner voice of a person of faith, though they may not be able to articulate it.
4. Construct a vision for recovery from madness for the people of faith.

Brewer-Smyth, K., & Koenig, H. G. (2014). Could Spirituality and Religion Promote Stress Resilience in Survivors of Childhood Trauma? Issues in Mental Health Nursing, 35(4), 251-256. doi:10.3109/01612840.2013.873101

Dworsky, C. K. O., Pargament, K. I., Wong, S., & Exline, J. J. (2016). Suppressing spiritual struggles: The role of experiential avoidance in mental health. Journal of Contextual Behavioral Science, 5(4), 258-265. doi:http://dx.doi.org/10.1016/j.jcbs.2016.10.002

Simon McCarthy-Jones, A. W. J. W. (2013). Spirituality and hearing voices: considering the relation. Psychosis: Psychological, Social and Integrative Approaches, 5(3), 247-258. doi:10.1080/17522439.2013.831945

Hessamfar, Elahe. In the Fellowship of His Suffering: A Theological Interpretation of Mental Illness—A Focus on "Schizophrenia." Eugene, Oregon: CASCADE Books, 2014.

Jones, Nev and Timothy Kelly and Mona Shattel. "God in the brain: Experiencing psychosis in the postsecular United States," Transcultural Psychiatry (2016): 1-18, accessed August, 6, 2016, DOI: 10.1177/1363461516660902.

Dircks, Sharon. Why?: Looking at God, Evil & Suffering. Inter-Varsity Press, 2013.

Martin, Jonathan. How to SURVIVE a SHIPWRECK: Help Is on the Way and Love is Already Here. Grand Rapids, Michigan: ZONDERVAN, 2016.

Ripken, Nik and Gregg Lewis. The Insanity of God. Nashville, Tennessee: B&H Publishing Group, 2013.

Rebecca Miller, PhD, Elan Cohen, Laura Delano, Tamar Lavy, MD, Sandra Steingard, MD
The Process, Practice, and Provocation of Discontinuing or Deprescribing Psychiatric Medication
Intermediate
Decreasing and stopping psychiatric medication is a topic gaining traction and attention both in the popular press and in academic and clinical settings. This panel will provide perspectives and practical information about the discontinuation/de-prescribing process, including viewpoints from activists, persons with lived experience, researchers, and psychiatrist-prescribers who will collectively explore meanings and manifestations of this aspect of medication use. To what extent can values promoting dialogue, shared decision making, and empowerment shake-up current practice? What is the current state of knowledge about barriers to implementation on the prescriber end, and what can we learn from the experiences of people along various stages of the process? How can we draw upon the growing knowledge and existing expertise of people with lived experience who have amassed a body of evidence around tapering protocols? The reversal of power between doctor and patient, and an increase of bidirectional knowledge sharing will be discussed. Join us in an exploration of this complex and important topic.

At the conclusion of this activity, participants should be able to:
1. Identify 3 meanings of medication that may influence discontinuation or deprescribing.
2. Explain 3 potential barriers to deprescribing identified by psychiatrists.
3. Name 3 potential supports which can assist in the discontinuation/deprescribing process.

Gupta, S., & Cahill, J. D. (2016). A prescription for "deprescribing" in psychiatry. Psychiatric Services, 904-907.

Mintz, D., Seery, E., & Cahill, J. (in press). Deprescribing: A psychodynamically-informed, patient-centered perspective. Current Psychiatry Reviews.

Ostrow, L., Jessell, L., Hurd, M., Darrow, S. M., & Cohen, D. (2017). Discontinuing psychiatric medications: a survey of long-term users. Psychiatric services, 68(12), 1232-1238.

Gogo Ekhaya Esima *Freedom, Expansion, and Growth in Altered States: Weaving the Spirit into Whole Person Care*
Introductory
Gogo Ekhaya Esima's deep understanding of mental illness comes from a solid background in both mental health treatment in the U.S. and traditional African healing.

Her own experience with mental illness eventually led her deeply into traditional African spirituality, which gives her the unique perspective she will be sharing. Through this expanded view, symptoms of mental illness are seen from the wider context in which they have long been perceived by many indigenous cultures.

In this way, the altered states of mental illness are seen as potential catalysts for not only recovery, healing, and growth but also the expansion of consciousness and development of new perspectives. This talk will reveal some of the positive benefits that come with altered states and also how providers can recognize and implement these viewpoints into their care. She will present a deeper look into what spiritual and soul level care is and why it is important, in addition to how it can lead through the challenges of mental illness to freedom and success.

At the conclusion of this activity, participants should be able to:
1. Explain how providers' view of altered states as a catalyst for healing and growth can improve the quality of their approach.
2. Contrast the level of care patients are most typically provided with the spiritual and soul level of care.
3. Describe the practical application of how providers can deepen the level of care they provide to reach the spiritual and soul level of care.

Austin, Philip Daniel, Macleod, Roderick, Siddall, Philip John, McSherry, Wilfred, & Egan, Richard (2016). The Ability of Hospital Staff to Recognise and Meet Patients' Spiritual Needs: A Pilot Study. Journal for the Study of Spirituality, 6 (1), 20-37. https://doi.org/10.1080/20440243.2016.1158453

Bell, David (2018). Incorporation of spiritual care as a component of healthcare and medical education: viewpoints of healthcare providers and trainees In Nigeria. The Nigerian Health Journal, 17 (3), 90-104. http://www.tnhjph.com/index.php/tnhj/article/view/328

Geier, J (Executive Producer), Kaplan, J. (Executive Producer), Borges, P. (Executive Producer & Director), & Tomlinson, K. (Executive Producer & Director). (2017). CRAZYWISE [Motion Picture]. United States: Northwest Film Forum

Puchalski, Christina M, Vitillo, Robert, Hull, Sharon K, & Reller, Nancy (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. Journal of Palliative Medicine, 17 (6), 642-656. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038982/

Pavan S. Brar, MA *Furthering the Dialogue between CBT for Psychosis and Phenomenology: Command Hallucinations, Beliefs, and Interpersonal Trust*
Intermediate
Traditionally, CBT for schizophrenia has placed an emphasis on addressing false or dysfunctional beliefs that are held as contributing to the formation and maintenance of symptoms. A self-disorder approach to schizophrenia (i.e. Sass, 2013; Henriksen, Raballo, & Parnas, 2015), as influenced by the

tradition of phenomenological psychopathology, however, raises questions as to the appropriateness of this theoretical stance for psychological treatment. Škodlar et al. (2012), for example, have argued that delusions are formed against a backdrop of a radically altered subjectivity, characterized by a pervasive sense of anxiety and uneasiness in relation to the world—delusional beliefs, thus, are expressions and attempts to express such an experience, rather than standard beliefs that can be challenged by counter-evidence. In light of such criticism, Škodlar et al. (2012) have pointed to a need for dialogue between CBT and a phenomenological approach to schizophrenia, so as to fortify available psychological treatments. The purpose of this paper is to further contribute to such dialogue. Focusing on the experience of command hallucinations, and drawing on Ratcliffe's (2017) phenomenological account of the emergence of voices, I will argue that certain cases of command hallucinations—and beliefs as to the power or omnipotence of such voices—can be understood as expressions of a deeply felt sense of uncertainty and mistrust in relation to others, oneself, and the world, as caused by interpersonal adversity or trauma. The standard CBT approach of challenging beliefs about voices, then, might be shown to have a limited therapeutic effect, given that such approach ignores the sense of disbelief in the positive potential of interpersonal relationships foundational to the emergence of many cases of 'powerful' voices. A rehabilitation of interpersonal trust, therefore, is advocated as central to recovery, and the implications of this for clinical practice are explored.

At the conclusion of this activity, participants should be able to:
1. Compare and contrast a cognitive-behavioral understanding of "belief" about voices with a phenomenologically informed understanding of ,"belief" about voices.
2. Examine and interpret the content of command hallucinations, and their negative appraisals, in a manner that is attuned to the possible traumatic/adverse context inherent to the voice-hearer's life history.
3. Discuss the role of interpersonal trust in reducing distress from voices and promoting recovery.

Henriksen, M. G., Raballo, A., Parnas, J. (2015). The pathogenesis of auditory verbal hallucinations in schizophrenia: A clinical-phenomenological account. Philosophy, Psychiatry, & Psychology, 22(3), 165-181.

Ratcliffe, M. (2017). Real Hallucinations: Psychiatric illness, intentionality, and the interpersonal world. Cambrdige, MA: The MIT Press.

Sass, L. A. (2014). Self-disturbance and schizophrenia: Structure, specificity, pathogenesis. Schizophrenia Research, 152, 5-11.

Škodlar, B., Henriksen, M. G., Sass, L. A., Nelson, B., Parnas, J. (2012). Cognitive-behavioral therapy for schizophrenia: critical evaluation of its theoretical framework from a clinical-phenomenological perspective. Psychopathology, 46(4), 249-265.

James E. Gorney, PhD *Freedom From Unrepresented States: The Music of Liberation*
Intermediate
A noteworthy characteristic of individuals in breakdown or other extreme states is immersion in unrepresented experience. Sustained engulfment in mindlessness, blanking out, numbing, emptying, and inability to think evokes and sustains subjective unreality, meaninglessness, and erosion of personal identity and agency. Entrapment in unrepresented states becomes a prison of solitary confinement, foreclosing access to necessary tools for constructing a coherent personal narrative. Feelings, impulses or desires seem to emerge at random; incoherence and fragmentation obscure the possibility of wholeness.

Within the psychotherapeutic situation, a critical challenge in working with those shackled within unformed and unformulated experience is to discover a path toward the creation of meaning. When the capacity to think is impeded, or even completely absent, traditional interpretive approaches of psychodynamic therapy or active interventions of cognitive/behavioral treatment alone will not likely prove sufficient to transform the patient's core predicament. In order to liberate those subjugated

through their own traumatized incoherence, the therapist must actively and imaginatively draw upon his own spontaneous, empathic, intuitive, and counter-transferential responses to co-create within the dyad inscriptions or registrations of meaningful representation. At critical junctures, the therapist may also need to initiate emotionally resonant action in order to invoke the emancipatory play of transitional space.

The long-term psychotherapy of a traumatized individual will be delineated, illustrating the tragic impact of life-long confinement within pervasive mindlessness. The possibility of making meaning and an escape into freedom was here engendered via the therapist actively introducing an artistic, symbolic, esthetic and sensory dimension into the therapeutic relationship. The patient's subsequent encounter with Beethoven's sublime account of relational devotion and human freedom in his opera Fidelio became transformative and liberating. Clinical and theoretical implications will be examined in regard to the unique capability of music for opening transitional space and creating conditions for the possibility of thought.

At the conclusion of this activity, participants should be able to:
1. Describe the concept of unrepresented states as they are manifested in traumatized individuals.
2. Describe the critical task in psychotherapy with patients in unrepresented states of the co-creation of symbolic meaning and a capacity for thinking.
3. Describe the importance of aesthetic experience, in particular that of music, in facilitating transitional space in psychotherapy with patients living in unrepresented states.

Levine, H.B., Reed, G.B., and Scarfone, D. (Eds.) (2013). Unrepresented States and the Construction of Meaning. London, England: Karnac Books.

Lombardi, R. (2016). Formless Infinity: Clinical Explorations of Matte Blanco and Bion. New York: Routledge.

Lombardi, R. (2017). Body-Mind Dissociation in Psychoanalysis: Development After Bion. New York: Routledge.

Meg Mateer, MBA, CPA, Grazyna Frackiewicz, Monique Greveling, M.Phil.
Healing Through Powerful Authenticity and Playful Connection
Introductory
Our current social code hinders human connection potential
- Reluctance to share individual struggle because of a fear of failure / judgement
- Emotions are constructed as primitive, overemphasis on cognition
- Interpersonal conflict is constructed as a hindrance, rather than an enhancement, to relationships
- Community support systems supports are lost amidst over professionalization of these services

How these dynamics are impacting society
- Rise of social isolation in western society, especially in vulnerable populations
- Increase in social compartmentalization, where people spend time mostly with those who have similar experiences and perspectives, and fear / hatred of difference
- Extreme states and burnouts have little community support, social isolation compounds the suffering of these experiences.

An opportunity for fostering new, open communities...
Empatiko is a new and growing global movement creating opportunities for people to challenge the status quo of a social code that keeps us disconnected by making opportunities for human connection more vivid, fun, daring, holistic, and creative. We believe the lived experience of extreme states is a gateway to a deeper sense of connection and community.

Why is the Empatiko approach to human connection unique?
1. We use play to humorously explore different aspects of our being human and to step outside of our

routine learned ways of being to dare to connect more authentically with ourselves and with others.
2. We stand for reflection! We believe in the power of authentic connection with others, which means that we dare to create opportunities for people to be mirrors for each other and to be a beacon where we have blinders on.
3. Want to live a more vibrant life? Up your emotional connection. We believe that by opening ourselves up to all emotions, we can more deeply feel, period. We invite opportunities for sharing both our triumphs and troubles.

At the conclusion of this activity, participants should be able to:
1. Appraise play as a unique way to discover more about yourself and others.
2. Explain how sharing vulnerability connects others to your own experience.
3. Demonstrate reflective listening as a method increasing empathy and clarity of others' experiences.

Bessel van der Kolk (2014), The body keeps the score. Brain, mind and body in the healing of trauma. Viking Penguin, New York.

Blume-Marcovici, Amy, ed. (2017), When therapists cry: reflections on therapists' tears in therapy. Routledge New York.

Brown, B. (2016). Daring Greatly: How the Courage to be Vulnerable Transforms the Way We Live, Love, Parent, and Lead. London: Penguin Books.

Gumley, A., Gillham, A., Taylor, K., Schwannauer, M. (2013), Psychosis and emotion. The role of emotions in understanding psychosis, therapy and recovery. Routledge London and New York. ISPS Series.

Jaak Panksepp on the importance of play (2017). In: Brainworld Bagazine October 2017 http://brainworldmagazine.com/dr-jaak-panksepp-the-importance-of-play/

Smith, Kimberley and Victor, C (2018) Typologies of loneliness, living alone and social isolation and their associations with physical and mental health. Ageing and Society. http://epubs.surrey.ac.uk/845719/3/Smith%20and%20Victor%202018.pdf Download May 17th 2018.

Toshiko Kobayashi, ATR-BC, LCAT, PhD(c), Faye Margolis, PhD, Kristina Muenzenmaier, MD
Our Inner Trauma Care: Non-verbal Approach for Self Care by Folding Paper
Introductory
This is an idea of using origami as a de-stressing and community building activity for people who are in behavioral therapy field. Those professionals who are in a position of caring other people with psychological and emotional needs tend to ignore their own needs for psychological and emotional care. Those professional people are too busy to take care of themselves but exposed to vicarious traumatization at work.

I found it is very important for professional people who are in the field to have a support system to take care of their own trauma before taking care of other people's trauma. This trauma care for professional people has been a subject I have been exploring.

While I have started to use origami in my art therapy practice, I noticed this type of community support practice of origami has been commonly practiced in China, Korea, and Japan. Extending the use of origami for staff care emerged when I was appointed to work as a coordinator of a Trauma Program for Staff, which was developed to foster a trauma sensitive and informed environment at a psychiatric hospital where I was working as an art therapist.

In order to do so it is important to have an environment where people can talk openly without judgmental criticism. Sharing creative non-verbal activity is one of the places where there is a potential of creating such an environment. Origami is a ubiquitous activity that has no restriction for gender, age,

ethnicity, and most importantly, since the process involves one folding at a time, which is within an easy access to all. It is universal to patients, treatment team, and all the workers in a hospital setting.

Origami is an activity which involves a direct use of fingertips; hand-eye motor coordination also has a unique quality that is mathematical and doesn't depend on verbal ability; verbal expressions as well as vision.

Even for some people who have negative preconceptions of origami from their past experiences, challenging a new approach of Expressive Origami Therapy has the potential of overcoming the preconceptions. The process of overcoming the negative preconceptions, which is a psychological process, is analogous to overcoming traumatic experiences.

We, the Trauma Program for Staff team, will talk about the importance of self-care and building supportive community through non-verbal approach to not just for our clients but for ourselves.

Process of the alternative project:
1. Exhibition of origami models folded by clients from 3 different settings:
Inpatients origami workshop, MICA residential program, and Accessible Origami program.

2. Open area where meeting attendants are free to come and fold.
Simple instruction will be provided by video and/or by demonstration.

3. Short lecture to introduce the background theories and history behind the project and open discussion.

At the conclusion of this activity, participants should be able to:
1. Demonstrate how to use at least one therapeutic origami model.
2. Discuss the importance of Origami for self care.
3. Apply origami to a group model.

Quelch, John A.; Knoop, Carin-Isabel (6 November 2014). "Mental Health and the American Workplace". Harvard Business School, School of Public Health (Rev. February 20, 2015)

Pearlman, Laurie Anne; McKay, Lisa (2009). "Understanding and addressing vicarious trauma" (PDF). Pasadena, CA: Headington Institute.

Kawachi, Ichiro; Berkman, Lisa F. (1 September 2001). "Social ties and mental health". Journal of Urban Health. 78 (3): 458,Äì467. doi:10.1093/jurban/78.3.458. ISSN 1099-3460. PMC 3455910,ÄØ

Origami in Mental Health therapy: George Ho (1993-2018)
https://sites.google.com/site/origamimind/advantages-of-using-origami-in-therapy/therapeutic-value-1.

Creativity in therapy: Carolyn Mehlomakulu http://creativityintherapy.com/2012/07/origami-in-therapy/

Kobayashi, Toshiko (2010). Enrichment Origami Art Therapy. In: K Stewart(Ed.) Music Therapy & Trauma (pp.167-175). New York: Satchnote Press.

Kobayashi, Toshiko (2007). Use of Origami for Children with Traumatic Experiences. In: S Brook(Ed.) The use of the Creative Therapies with Sexual Abuse Survivors (pp. 102-120). Springfield, Illinois: Charles C Thomas.

Kobayashi, Toshiko (2005).Enrichment Origami Art Therapy with the People at the Lower Eastside. Care Study #4. Tokyo, Japan: Index Press.

Joseph I. Abrahams, MD *The Synergy of the Family Community Group and Psychoanalysis in the Treatment of Psychosis*
Advanced
In this clinical presentation, the author details background experience, theory and practice in combining individual psychoanalysis, family therapy, and therapeutic community. After presenting illustrative literature on the subject, he goes into historical review of a therapeutic community devoted to work with young adult schizophrenics. He concludes with somewhat detailed case history material.

At the conclusion of this activity, participants should be able to:
1. Discuss the interaction of individual and group psychoanalytic factors.
2. Relate these factors to accounts in the literature in psychoanalytic family therapy.
3. Illustrate how the group processes enabled individuals and families to resolve their pathological issues.

Brian Martindale (2017). British Journal of Psychotherapy, 33(2):224-238. A Psychoanalytic Contribution to Understanding the Lack of Professional Involvement in Psychotherapeutic Work with Families Where there is Psychosis.

Ronald Abramson, M.D. (2010). Journal of American Academy of Psychoanalysis, 38(3):483-502 Psychotherapy of Psychoses: Some Principles for Practice in the Real World.

Willem H. J. Martens (2012). International Forum of Psychoanalysis, 21(2):68-81. Healing dynamics of psychosis

Abrahams, J., Terra Incognita: A Psychoanalyst Explores the Human Soul, University Press 2014.

Abrahams, J., Circles of Change. In publication.

Abrahams, J., Democracy From the Grass Roots. 2nd edition in publication.

Gary L. Borkowski, DVM, MS *The Psychosis Recovery Race - A 10K or a Marathon*?
Intermediate
When a loved one experiences psychosis, helping them get better can become a full-time endeavor. The desire to help and support can lead to an urgency towards recovery. A realization and an acceptance that timelines may be much longer than for many other illnesses is vital to all involved. There are many decisions involved, and sometimes urgent responses to events are necessary when psychosis affects a loved one. A review of some of these decision points and an explanation of alternatives will be presented. A review of a 10 year history of support and struggles for psychosis recovery, based upon personal/family experience will be the overarching theme/context for this presentation/discussion.

At the conclusion of this activity, participants should be able to:
1. Discuss options and alternatives for supporting a loved one in psychosis recovery.
2. Explain the importance of a long-term perspective for the management and support in psychosis recovery.
3. Explain that psychosis is serious and manageable.

Living with psychosis: strategies and social conditions for recovery (https://www.tandfonline.com/doi/abs/10.1080/17522439.2018.1447595) (2018)

Cognitive Analytic Therapy for psychosis: A case series (https://onlinelibrary.wiley.com/doi/abs/10.1111/papt.12183) (2018)

Recovery, Meaning-Making, and Severe Mental Illness: A Comprehensive Guide. By Paul H. Lysaker, Reid E. Klion (2017)

Françoise Davoine, PhD *The Psychoanalysis of Extreme States: The Creation of Liberty*
Introductory
The topic of this conference is for me an occasion to give evidence that the psychoanalysis of psychosis and traumas leads to the creation of liberty. This expression has been used by former patients who came back recently to see me, free from delusions and withdrawal symptoms, to testify about the freedom they achieved by investigating silenced abuses both on an individual and political scale. I will insist on the necessity for the analyst to ask questions, triggered from his own historical background, and as usual, will use literary references, in a dialogue with clinical stories.

At the conclusion of this activity, participants should be able to:
1. Discuss how psychoanalysis of psychosis and traumas leads to the creation of liberty.
2. Explain how freedom can be achieved by investigating silenced abuses both on an individual and political scale.
3. Discuss the need for the analyst to ask questions, triggered from his own historical background

F. Davoine. *Mother Folly*, Stanford University Press, 2014.

F. Davoine. "Siri's Timequakes", (about Siri Hustvedt's novel: *The Sorrows of an American*, 2008) in: *Zones of Focused Ambiguity in Siri Hustvedt's Works*. Edited by Johanna Hartmann, Christine Marks, Hubert Zapf. Anglia Books Series, 2017.

F. Davoine and J.M. Gaudillière:
"The psychoanalysis of psychosis at the crossroads of individual stories and of history." Ch.5 in *Psychoanalysis and Holocaust Testimony. Unwanted Memories of Social Trauma*. Edited by Dori Laub and Andreas Hamburger. Routledge 2017.

F. Davoine, J.M. Gaudillière. *A word to the wise! Don Quixote's return to fight perversion*. Karnac Books 2018.

Chrétien de Troyes, Perceval the Welsh. The story of the Fisher King. XIIth century.

Jim Probert, PhD *A Human Rights Approach to Supporting Individuals Experiencing Extreme States on a College Campus*
Intermediate
Imagine facilitating LGBTQ+ empowerment groups back when openly identifying as gay was diagnosable as an impairment excluding professionals from licensure. When I went mad, in 1982, release from a locked ward required me to concede my extreme states were caused by an incurable chemical imbalance. As I wrote for SAMHSA, I recovered my life through reclaiming authorship of my own experience, from many perspectives—including varied understandings of trauma, spirituality, and emotion experienced in human connection. Still, I faced compelling pressure, in graduate school, to engage distressed human beings only within strictly clinical perspectives—which I had experienced as conversion therapy. Then, I worked for years as a University of Florida therapist—collaborating with many students experiencing extreme states—before I risked talking about my life.

Now, the UF Counseling and Wellness Center highlights a “Human Rights Approach.” Peer support alternatives and professional training in rights-based, trauma-informed suicide prevention and mental health recovery are acknowledged as “critical indicators” of movement toward compliance with a 2017 UN Human Rights Council report.

The CWC offers Intentional Peer Support and Wellness Recovery Action Plan groups--and, recently, IPS Core Training. Professionals facilitating peer support acknowledge our lived experience—including mine, living under the umbrella of the Hearing Voices movement. I also facilitate Experiential Peer Support groups--incorporating HV Network training-- for “exploring voices, visions, plurality, presences, premonitions, and other extreme, ‘unusual,’ poetic, spiritual or otherwise alternative beliefs, perspectives, or experiences.”

A social justice perspective is transforming clinical services. Students retain access to conventional approaches, including psychiatry. Therapists also increasingly acknowledge student clients deserve the same fluidity for establishing those identities--which include what the UN report calls, "the diversity of human experience and the variety of ways in which people process and experience life"--as they do for other historically excluded social identities.

At the conclusion of this activity, participants should be able to:

1. Describe key concepts of the 2017 United Nations Human Rights Council's report from a social justice perspective--emphasizing both the importance of individual agency and the crucial shaping role of systemic and community forces.
2. Explain how rights-based, trauma informed clinical training in suicide prevention and mental health recovery can contribute both to a reduction in non-consensual and coercive clinical interventions and to a corresponding increase in rights-based, trauma-informed support for individuals experiencing extreme states.
3. Discuss how the presence and availability of relatively non-compromised peer support alternatives--facilitated by individuals with lived experience--can support both increases in agency among individuals experiencing extreme states and a gradual transformation of the perspectives and responses of clinicians.

Longden, E., Read, J., & Dillon, J. (2017). Assessing the impact and effectiveness of hearing voices network self-help groups. Community Mental Health Journal, 1–5.

Longden, E., & Read, J. (2016). Social Adversity in the Etiology of Psychosis: A Review of the Evidence. American Journal of Psychotherapy. 70. 5-33.

Pūras, D. (2017). Human rights and the practice of medicine. Public Health Reviews, 38, 9.

Probert, J. & Nash, S. (January 1, 2018). Challenges and opportunities awaiting the field in 2018. Mental Health Weekly, 28 (1): 4. (Republished, with edits and additional resources, as "Human Rights Approach to Mental Health" on the University of Florida Counseling and Wellness Center website. https://counseling.ufl.edu/wrap/)

Probert, J. (2017, August). An Approach to Mental Health Recovery and Cultivating "Emotional Fitness" for Wellness Recovery Action Plan (WRAP) Users . . . and Anyone Else! Alternatives Conference. Boston, MA. (Workshop handout.)

Probert, J. (2017.) About Experiential Peer Support. A University of Florida Counseling and Wellness Center group. UF CWC website. https://counseling.ufl.edu/services/gw/groups/experiental/

Probert, J. & Nash, S. (2015, November). Mental Health Recovery and Peer Support at UF: A Social Justice Perspective. Invited poster presentation at the UF Social Justice Summit, Gainesville, FL. (Poster and references.)

Probert, J. (2015, April). *Toward a more trauma-informed and recovery-oriented practice of lethality assessment and suicide prevention.* Workshop presented at American Association of Suicidology Conference, Atlanta, GA. [Instructional multimedia presentation and references available at https://www.researchgate.net/profile/Jim_Probert/publications]

Nash, S. & Probert, J. (2014, October). *Intensive Coordinated Support at the University of Florida*. Presentation to Dr. David Kratzer, the University of Florida Vice President of Student Affairs and the Vice President's advisory council, Gainesville, FL. [Intensive Coordinated Support is a program incorporating peer support, a drop-in recovery center and coordinated clinical care. During this presentation, we received the Vice President's support for moving forward with this program.]

Probert, J. (February 27, 2014.) Part 1. Toward a more trauma- and recovery-informed practice of lethality assessment and suicide prevention. *SAMHSA Recovery to Practice Highlights*, 5 (4). Retrieved from http://www.dsgonline.com/rtp/wh/2014/2014_02_27/WH_2014_02_27.html

More resources are available, with references, at:
www.researchgate.net/profile/Jim_Probert/publications

Ira Steinman, MD *CATATONIC PSYCHOSIS or BEATIFIC STATE: Successful Intensive Psychotherapy of Profoundly Disturbed States*
Intermediate
Intensive Psychodynamic Psychotherapy of Psychosis has become a nearly lost art. Yet, a dynamic psychotherapy using concepts of transference, unconscious motivation and symbolization, as well as counter transference and resistance to understanding these phenomena, is well known to be helpful in the treatment of better put together people, as previously unconscious phenomena are interpreted and made clear.

It also can be healing and, at times, curative in the exploration and psychotherapeutic treatment of psychosis. Here delusions and hallucinations are dealt with as what they are: unrecognized creations of the psychotic patient.

In my Karnac books, TREATING the 'UNTREATABLE' and SELF PSYCHOLOGY and PSYCHOSIS: the Development of the Self during the Intensive Psychotherapy of Schizophrenia and the other Psychoses, such a clinical improvement and cure are clearly demonstrated. I will highlight the efficacy of such a therapeutic approach in the following clinical presentation.

This is a case of a spiritual seeker, a Baba lover, who hungered for union with the cosmos. He had been psychotic for more than 20 years, refusing to see psychiatrists who only medicated him to no avail. He came to my office, a seer with an extremely long beard; pulled and pushed into the office by his family would be more correct.

His previous diagnosis was catatonic schizophrenia. Yet, in the course of our uncovering work, it became clear that he was lucid and well versed in Hindu theology and cosmology. He appeared psychotic to family and previous treaters; to me he was highly intelligent and bent on achieving union with the godhead.

This is the tale of such a quest and how Intensive Psychotherapy aided and cured this seeker, and protected him from the hospital and other psychiatrists who wanted to treat his "catatonic " schizophrenia with shock therapy.

Such an Intensive Psychotherapeutic approach brought this seemingly psychotic man, who I saw as an inquiring saddhu, through his many years of psychosis and silence to a place where he can now talk, be with friends, go to conferences and enjoy his daily life, no longer beset by hallucinations and delusions.

Once again, Intensive Psychotherapy, can be shown to be curative in the treatment of psychosis.

At the conclusion of this activity, participants should be able to:
1. Explain that some profoundly disturbed people can respond to, and be healed by, an Intensive Psychodynamic Psychotherapy.
2. Discuss that the exploration of hallucinations and delusions may lead to major curative psychological changes.
3. Assess their own patient caseload as to the advisability of such an exploratory approach.

Glover, J, Alien Landscapes, Hqrvard, Belknap 2014

Guntrip, H; Schizoid Phenomena, Object Relations, and the Self, International Universities Press, New York, 1969

Marcus, E, Psychosis and Near psychosis, Routledge, 3rd ed, 2017

Steinman, I, Treating the "Untreatable": Healing in the Realms of Madness, Karnac Books, London, 2009

Steinman, I with Garfield D, Self Psychology and Psychosis: The Development of the Self during Intensive Psychotherapy of Schizophrenia; Karnac Books, London 2015.

Sunday, November 11

Honoree Address: Krista MacKinnon

Mobilizing The Wisdom of The Recovery Model For Whole Family Healing

Introductory

Families deserve support and education that responds to their holistic needs and concerns as individuals and as a whole family as they overcome mental health struggles. This talk will explore the existing climate individuals and families face when seeking help for complicated emotional distress, the damage that the implicit bias inherent in the mental health system can have on families, as well as the remarkable benefits of educating families in mental health recovery. In closing, this talk will share a vision for a whole and comprehensive approach to families healing together and invite participants to consider their capacity to contribute to co-creating this culture of healing.

At the conclusion of this activity, participants should be able to:

1. Differentiate between the present climate of family support services offered in the mental health system and the necessary emerging approach of the family mental health recovery model.
2. Specify the complex and multifactorial elements involved in whole family mental health recovery in the realms of culture, the mental health system, the family, and the individual self.
3. Evaluate personal social location regarding co-creating a culture and mental health system that embraces humility over authority, connection over coercion, and family connectedness over isolation.

Estrada, S. (2016). Families Healing Together: Exploring a Family Recovery Online Course. Qualitative Report, 21(7), 1216-1231. Retrieved from hBp://nsuworks.nova.edu/tqr/vol21/iss7/3

Lisa A. Rue, Samantha Estrada, Michael Floren, Krista MacKinnon. (2016) Evaluation and Program Planning 55, 27–34 Formative evaluation: Developing measures for online family mental health recovery education

MacCourt P., Family Caregivers Advisory Committee, Mental Health Commission of Canada. (2013). National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses. Calgary, AB: Mental Health Commission of Canada.

Cyr Céline, McKee Heather, O'Hagan Mary and Priest Robyn, for the Mental Health Commission of Canada (2010 first edition / 2016 second edition). Making the Case for Peer Support: Report to the Peer Support Project Committee of the Mental Health Commission of Canada.

Cooke, A. (Ed). (2014). Understanding Psychosis and Schizophrenia: Why people sometimes hear voices believe things that others find strange, or appear out of touch with reality, and what can help. A report by the British Psychological Society Division of Clinical Psychology.

Hall, Will (2016) Outside Mental Health Voices and Visions of Madness. United States. Madness Radio.

Forbes, Rossa. (2018) The Scenic Route: A way through Madness. Inspired Creations, LLC

Siegel, D.J. (2017). Mind: a journey to the heart of being human. New York: W. W. Norton.

Kinderman, P. (2014). A prescription for psychiatry. London: Palgrave Macmillan.

Plenary: Pat Wright, M.Ed, Stella Allison, Bill Cahalan, PhD, Deborah Jordan, RN, M.Ed., David "Tad" Randall, Dina Tyler *The Family: Transformation to Powerful Ally*

Introductory

Our 3rd annual family plenary will discuss some of the stages families pass through in pursuit of healing for both themselves as well as their loved ones in experiencing extreme states. The panel will highlight how families can consciously (re)write the narrative from "victim", "sick", ''patient" to "spiritual crisis", "awakening" and "warrior on the path to wholeness".

At the conclusion of this activity, participants should be able to:

1. Identify the language that will determine whether the outcome of families "telling their story" will result in draining their energy (hopelessness, despair, negative) or empowerment (courageous, hopeful, life-giving).
2. Discuss how the family changes as a culture upon attempting to "help" their loved ones on choosing to enter the "established medical system". Also, what are the other choices and how do we expand them?
3. Describe the multiple power dynamics within the family as well as those between the family and the professionals in seeking healing.

Greek, Milt. Delusions, Meaning and Transformation. 2014.

Love, Janet C. Psychosis in the Family: The Journey of a Transpersonal Psychotherapist and Mother (United Kingdom Council for Psychotherapy Series) Dec 31, 2009

Van der Kolk, Bessel. The Body Keeps the Score. 2015

Whitaker, Robert. Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform. 2015.

Breakout Sessions

Claire L. Bien, MEd *Moving Beyond Pain, Confusion, and Anger: Learning to Negotiate with the Voices in Our Heads*

Intermediate

One of the most astonishing revelations for people who hear voices and the mental health professionals who work with them is that it is possible to create a peaceful rapprochement with the voices by approaching them with the utmost kindness and respect. Learning to stand up to our voices, making appointments to talk, and challenging the validity or veracity of their pronouncements and demands can further change the relationship in ways that can be very beneficial. Thanks to the development and growth of the Hearing Voices Network and the supports offered by these groups worldwide, often combined with compassionate psychotherapy, many voice hearers have found the hope, inspiration, friendship, and guidance needed to speak to and learn from our voices. In so doing we have developed insight into the fact that some of our most difficult voices are born of our most carefully guarded secrets and deeply painful and repressed emotions. Learning to address our secret pain and accompanying emotions, and gaining understanding of ourselves as individuals and in the context of others and the world, fosters resilience and helps strengthen the foundation on which we can build our recoveries.

Drawing upon personal and professional experience, including selected readings from my memoir, Hearing Voices, Living Fully, this presentation will provide information and insight into the nature of voice hearing and its potential causes. Content will touch upon forms of trauma, social and environmental triggers, factors that foster resilience, and coping skills. A portion of the presentation will describe how I learned to stand up to my voices and, through a discipline of self-guided and professional therapy, gained the self-understanding, self-respect, and courage needed to challenge my demons and negotiate the conditions that have allowed me to regain control over my mind and life, even while continuing to hear intermittent voices.

At the conclusion of this activity, participants should be able to:

1. Describe and discuss some of the social, societal, and environmental factors that can lead to psychosis in vulnerable individuals and be able to name a minimum of three common triggers to hearing voices, three coping skills commonly used to ease or manage distress, and three factors that foster resilience.
2. Speak to the fact that many voice hearers can develop mutually beneficial relationships with their voices by treating them with kindness, understanding, and respect, and requesting that their voices treat them with similar understanding and respect.
3. Cite research indicating that voice hearers who learn to stand up to their voices can shift the power balance and thereby reduce their level of distress from even the most difficult voices.
4. Cite a minimum of three negotiating strategies successfully used by voice hearers to reframe our relationship with our voices.

Bien, C. Hearing Voices, Living Fully: Living with the Voices in My Head. (2016) London: Jessica Kingsley Publishers.

Bien, C. and Reis, G. The Hearing Voices Movement: Mental Health Advocacy and Recovery. Cadernos Brasileiros de Saúde Mental, ISSN 1984-2147, Florianópolis, v.9, n.21, p.81-90, 2017.

Cook, Anne, Ed. Understanding Psychosis and Schizophrenia: Why people sometimes hear voices, believe things other people find strange, or appear out of touch with reality and what can help. (2014) Leicester, UK: The British Psychological Society Division of Clinical Psychology.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., and Thomas, N. Emerging perspectives from the Hearing Voices Movement: Implications for research and practice. (2014): Schizophrenia Bulletin, 40(4), S285-S294.

Dillon, J., and Hornstein, G.A. (2013). Hearing voices peer support groups: A powerful alternative for people in distress. Psychosis: Psychological, social, and integrative approaches, 5(3), 286-295.

Geekie, J., Randal, P., Lampshire, D. and Read, J. Experiencing Psychosis: Personal and Professional Perspectives. (2012). East Sussex, UK: Routledge.

Gumley, A., Gillham, A. Taylor, K. and Schwannauer, M. Psychosis and Emotion: The Role of Emotions in Understanding Psychosis, Therapy and Recovery. (2013). East Sussex, UK: Routledge.

McCarthy Jones, S. Can't You Hear Them? The Science and Significance of Hearing Voices. (2017). London: Jessica Kingsley Publishers.

Powers, A.R., Bien, C., and Corlett, P. Aligning Computational Psychiatry with the Hearing Voices Movement: Hearing Their Voices. JAMA Psychiatry 75:6, June 2018. Published online May 2, 2018: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2679766?redirect=true

Powers, A.R., Kelley, M., and Corlett, P. Varieties of Voice-Hearing: Psychics and the Psychosis Continuum. Schizophrenia Bulletin, Volume 43, Issue 1, 1 January 2017, Pages 84–98, Published online October 7, 2016. https://doi.org/10.1093/schbul/sbw133

Powers, A.R., Mathys, C., and Corlett, P.R. Pavlovian conditioning-induced hallucinations result from overweighting of perceptual priors. Science, Vol. 357, issue 6351, 11 Aug. 2017, pp. 596-600.

Rowe, M. Citizenship and Mental Health (2015). London: Oxford University Press.

Southwick, S., and Charney, D. (2012). Resilience: The Science of Mastering Life's Greatest Challenges. London: Cambridge University Press.

Styron T., Utter L., and Davidson L. The hearing voices network: initial lessons and future directions for mental health professionals and systems of care. Psychiatr. Q. 2017;88(4):769-785.

Noël Hunter, PsyD & Marie Brown, MA
Trauma and Trauma-Informed Care in the Treatment of Psychosis
Introductory
This presentation will begin with a brief overview of what we mean when referring to "trauma", and will follow with an overview of the research as it pertains to rates of adversity and trauma in people diagnosed with psychosis; findings within the neurological and psychological research on the cognitive and neurocognitive effects of trauma, and the ways in which mental health professionals can practice more trauma-informed care. Included in the presentation will be various practical approaches to working with trauma in psychosis, including from Hearing Voices, psychodynamic, and cognitive-behavioral perspectives. Participants will also learn about post-traumatic growth and the ways in which healing from trauma is related to personal growth and what survivors of trauma have found helpful in healing.

At the conclusion of this activity, participants should be able to:
1. Define trauma and adversity in a more culturally-sensitive and inclusive manner.
2. Engage in dialogue about barriers within their work settings to being more trauma informed and ways in which they can work within these parameters.
3. Identify at least 3 ways that trauma affects the brain, cognitions, and people's ways of viewing the world.

Blom J D, and Mangoenkarso E. (2018). Sexual Hallucinations in Schizophrenia Spectrum Disorders and Their Relation With Childhood Trauma , Frontiers in Psychiatry , 9, DOI=10.3389/fpsyt.2018.00193

Cragin C. A., Straus M. B., Blacker D., Tully L. M., & Niendam T. A. (2017). Early Psychosis and Trauma-Related Disorders: Clinical Practice Guidelines and Future Directions , 8, DOI=10.3389/fpsyt.2017.00033

Rachel M. et al., (2018). Do trauma-focused psychological interventions have an effect on psychotic symptoms? A systematic review and meta-analysis, Schizophrenia Research , 195 , 13 - 22, DOI: https://doi.org/10.1016/j.schres.2017.08.037

Phoebe Friesen, PhD, Elan Cohen, Tamar Lavy, MD, Christina Wusinich, MS
Parachute NYC: Experiences of Participants, Family Members, and Team Members
Introductory
Between 2012 and 2018, Parachute NYC provided a 'soft landing' for people experiencing psychiatric crisis, utilizing the natural support network in a patient's life and minimizing medical service use by fostering supportive communities (Pope, Cubellis, & Hopper, 2016). Individuals and their families received regular home visits from Parachute teams, consisting of peer specialists and licensed health care professionals, including social workers, family therapists, and psychiatrists. Team members received training in both the Need Adapted Treatment Model (now developed into Open Dialogue), which espouses a practice of healing through polyphonic (many voices) dialogue and a tolerance of uncertainty within a non-hierarchical network, and Intentional Peer Support, which embraces crisis as opportunity, mutual accountability within partnerships, and trauma-informed care (Aaltonen, Seikkula, & Lehtinen, 2011; Alanen, Lehtinen, Rakkolainen, & Aaltonen, 1991; Mead, Kuno, & Knutson, 2013).

This panel, run by a peer specialist and psychiatrist from Parachute NYC, as well as a researcher and philosopher who collected both quantitative and qualitative data from both participants and family members receiving Parachute services, will explore the experiences of several stakeholders involved in Parachute. Drawing on interview data with family members and participants, as well as direct experiences of Parachute team members, the presentation will weave between individual narratives and case studies, quantitative data, and exemplary quotations from interviews. Themes that will be explored include the difficulties involved in implementing this type of approach in a context such as New

York City, the ways in which the peer specialist role on the team was navigated by all team members, the aspects of the program that participants and family members found most rewarding and most challenging, and the aspects of this experience that can help to inform other alternative programs within the mental health system (Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016; Salzer, Schwenk, & Brusilovskiy, 2010).

At the conclusion of this activity, participants should be able to:

1. Describe the basic principles underlying the Need Adapted Treatment Model and Intentional Peer Support.
2. Identify the central features of Parachute NYC.
3. Examine the experiences of those involved in Parachute NYC in relation to their own experience in the mental health system.

Aaltonen, J., Seikkula, J., & Lehtinen, K. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states. Psychosis, 3(3), 179-191. doi:10.1080/17522439.2011.601750

Alanen, Y. O., Lehtinen, K., Rakkolainen, V., & Aaltonen, J. (1991). Need-adapted treatment of new schizophrenic patients: experiences and results of the Turku Project. Acta Psychiatrica Scandinavica, 83(5), 363-372.

Gordon, C., Gidugu, V., Rogers, E. S., DeRonck, J., & Ziedonis, D. (2016). Adapting Open Dialogue for Early-Onset Psychosis Into the U.S. Health Care Environment: A Feasibility Study. Psychiatric Services, appi.ps.201600271. doi:10.1176/appi.ps.201600271

Mead, S., Kuno, E., & Knutson, S. (2013). Intentional peer support. Vertex (Buenos Aires, Argentina), 24(112), 426-433.

Pope, L. G., Cubellis, L., & Hopper, K. (2016). Signing on for dirty work: Taking stock of a public psychiatry project from the inside. Transcult Psychiatry, 53(4), 506-526. doi:10.1177/1363461516655947

Salzer, M. S., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: results from a national survey. Psychiatric Services, 61(5), 520-523. doi:10.1176/appi.ps.61.5.520

Brian Koehler, PhD, Philip T. Yanos, PhD, Mark Salzer, PhD

Towards Freedom from Stigma: Let No One be Written Off

Introductory

This panel is devoted to an interrogation of the words and practices that are in common use regarding people who are in deep distress, but that end up causing sometimes equally deep harm to the very people they aim to diagnose and treat. In “Why the World Health Organization and the American Psychiatric Association should drop the term “schizophrenia,” Brian Koehler notes that the term “schizophrenia” has become synonymous with dangerousness even though it is a very small minority of persons with this diagnosis who violently hurt others. The term is also associated with non-recoverability. Dangerousness and non-recoverability seem to be hard-wired into the diagnosis. The term encompasses a heterogeneous group of people with different “symptoms,” etiologies, course and outcomes, while inequitable application of the term reinforces social oppression which can become biologically embedded, resulting in epigenetic changes to gene expression, and which in turn may be potentially transmitted across generations. The term takes away hope and agency, the lynchpins of recovery, even while recovery is possible; nine world outcome studies and the World Health Organization studies on “schizophrenia” demonstrate substantial recoveries. Japan, Hong Kong, Taiwan and South Korea have dropped the term “schizophrenia.” The time is now, Koehler asserts, to drop this stigmatizing, hope-disabling, scientifically controversial and compromised term.

The call to discard stigmatizing terminology resonates with the arguments put forward by Philip Yanos in his book, *Written Off* (Cambridge University Press, 2018). In this book discussion between Yanos and Mark Salzer, the audience will hear how mental health stigma comes to have a profound impact on the lives of people diagnosed with mental illnesses. A major contention of the book, consistent with ISPS's mission, is that "biological-reductionistic orientation" narrative about mental illness has been damaging to people with mental health diagnoses. Furthermore, the book argues that societal discussions of stigma need to move beyond just encouraging help-seeking, since, as the book demonstrates, people who are receiving services are often those who are most negatively impacted by stigma. Following an overview of major areas covered in the book by Dr. Yanos, Mark Salzer will offer comments and questions, and then Drs. Yanos and Salzer will engage audience members in a "community conversation" about the topic of stigma and its implications.

At the conclusion of this activity, participants should be able to:
1. Offer one scientific reason why the term "schizophrenia" should be dropped.
2. Offer three reasons why the term "schizophrenia" is highly stigmatizing to those people given this diagnosis.
3. Identify ways that the internalization of stigma impacts community participation.
4. Identify ways to counteract community and internalized stigma.

van Os, J. (2016).Views & Reviews Personal View "Schizophrenia" does not exist. BMJ 2016; 352

Causal beliefs and attitudes to people with schizophrenia. Trend analysis based on data from two population surveys in Germany, MATTHIAS C. ANGERMEYER, HERBERT MATSCHINGER. The British Journal of Psychiatry Mar 2005, 186 (4) 331-334

Lasalviaa, A. et al. (2015). Should the label "schizophrenia" be abandoned? Schizophrenia Research 162: 276-284.

Yanos, P. T. (2018). *Written off: Mental health stigma and the loss of human potential*. New York: Cambridge University Press.

Gonzales, L., Davidoff, K., Nadal, K., & Yanos, P. T. (2015). Microaggressions experienced by persons with mental illness: An exploratory study. Psychiatric Rehabilitation Journal, 38, 234-241.

Salzer, M. S., Brusilovskiy, E., Prvu-Bettger, J., & Kottsieper, P. (2014). Measuring community participation of adults with psychiatric disabilities: Reliability of two modes of data collection. Rehabilitation Psychology, 59(2), 211-219

Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The impact of illness identity on recovery from severe mental illness. American Journal of Psychiatric Rehabilitation, 13, 73-93.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. Clinical Psychology: Science and Practice, 9, 35-53.

Meidan Turel, MA, Michael A. Siglag, PhD, Marilyn Charles, PhD, ABPP, Hilik (Yechiel) Peri, MA, Sally E. Riggs, DClinPsy, ACT, Paul S. Saks, PhD *Pursuing Wholeness in Extreme States: The Work of Clinical Psychologists in Inpatient Mental Health Settings*
Intermediate
Many individuals suffering from extreme states of distress and disorganization receive treatment in inpatient mental health settings. Within these settings, Clinical Psychologists often serve as prominent members of the multi-disciplinary staff, carrying out a variety of interventions unique to their profession and training. Yet in these settings, psychologists often face significant challenges in their quest to provide healing and integrative experiences for individuals in their care.

The members of this panel, all psychologists working in inpatient settings, describe such challenges

present in their work, and their means of addressing and resolving them. Marilyn Charles describes her use of psychoanalytic and field theories to provide meaning and emotional understanding to the ongoing work and complex human situations in her hospital, and how this contributes to therapeutic efficacy. Hilik Peri provides a window into his work in the intense environment of a forensic inpatient mental health unit. Hilik describes the creation of a therapeutic space, an emotional frame containing tensions between individuals' internal world, the realities and limitations of the ward environment, and individuals' potential for violence. Sally Riggs describes her use of CBT for Psychosis as a core technique for engagement and treatment in her work on the inpatient unit. She describes how interactions consistent with this model can facilitate faster and more lasting recovery for clients. Paul Saks describes how psychological assessment in a public hospital setting plays a vital role in enhancing understanding of the individual's therapeutic needs, potentially contributing to better treatment outcomes. Meidan Turel and Michael Siglag both have experience leading psychology departments in public psychiatric hospital settings, and are editors (together with Professor Alexander Grinshpoon) of a book about psychologists' work in such settings. They discuss crucial roles psychologists can play advocating for holistic and patient centered care for those presenting extreme states in inpatient mental health settings.

At the conclusion of this activity, participants should be able to:

1. Explain one way in which a CBT for Psychosis model can impact engagement and treatment in institutional settings.
2. Describe one way in which dynamic formulations can facilitate understanding of the individual and contribute to more humane and holistic treatment in institutional settings.
3. Identify one significant aspect of the therapeutic relationship between therapist and patients unique to a forensic context.
4. Describe one way in which a battery of intelligence, neuropsychological, objective personality and projective tests can be used to provide crucial insight into diagnosis and treatment.

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Katie Bourque & Jason Young *Soteria: Exploring Extreme States Together*

Introductory

Pathways Vermont's Soteria is a unique therapeutic community residence in Burlington, Vermont informed and inspired by Loren Mosher's Soteria project. The results of the original Soteria study and more recent inquiries into the nature of mental health have provided us with insight and tools by which to explore our experiences and find possibilities for personal transformation within crises. Our core mission is to prevent hospitalization and minimize exposure to medication with early intervention and individualized support.

This presentation will describe how Soteria engages residents in a manner that is supportive to fundamental well being and how we have learned to appreciate the profound impact we have on one

another, as we work towards a collaborative, self-directed, means to promoting healing. Soteria seeks to empower people by cultivating narratives of resilience through relationships of equality.

We have identified several tools and values that help guide our work, including: Intentional Peer Support (IPS), trauma informed care, and harm reduction. Intentional Peer Support is a movement developed and led by two Vermont innovators and serves as our core training at Pathways Vermont. Staff have a great deal of flexibility to allow for the development of individual relationships. We aspire to "be with" residents in an effort to establish mutual and meaningful connection. We offer access to a range of peer groups and services in addition to medical and therapeutic professionals.

Our presentation will detail the development and foundational philosophies of the Pathways Vermont's Soteria program over the first three years.

At the conclusion of this activity, participants should be able to:
1. Explain how intentional peer relationships can be used to support mutual well being.
2. Describe how experiences that may alienate others can serve as points of connection.
3. Describe the history, philosophy and implementation of the Soteria model of care.

Maria J. O'Connell, Ph.D. ,William H. Sledge, M.D., Martha Staeheli, Ph.D., David Sells, Ph.D., Mark Costa, M.D., Melissa Wireland, Ph.D., & Larry Davidson, Ph.D. (2018). Outcomes of a Peer Mentor Intervention for Persons With Recurrent Psychiatric Hospitalization. APA Publishing.

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Swapnil Gupta, MD *"Who am I without Haldol?" – The Personal and Social Meanings of Deprescribing*
Intermediate
Introduction: People who take antipsychotic medications for long periods, construct an identity around the treatment. Medication may form the center of organization of their daily routine and social supports and affect relationships. So, what happens when the patient and doctor decide to try to reduce or stop medication, or deprescribe? Through a case example, this paper illustrates how the deprescribing can affect a person's identity and their engagement with his world. It also describes how this struggle forms a part of the ambivalence regarding deprescribing and how mental health professionals can help people work through it.

Case history: Gary is a 50-year-old man who, in his twenties, was told he had to take Haldol for the rest of his life. The suggestion that he could lead a life without Haldol angered him and prompted immediate rejection of the idea. This was soon followed by euphoric agreement with the suggestion. Gary swung back and forth for months, and by working through a myriad of emotions, could begin to imagine a future without Haldol.

Discussion: Deprescribing requires the acknowledgement of the profound effect that chronic medication treatment has on self-image and relationships. It may involve the task of coping with a fearful, yet desired shift in agency and power and the with the loss of medication as an object of rage and love. Professionals helping their patients through the process of deprescribing need to anticipate and discuss these challenges in advance.

At the conclusion of this activity, participants should be able to:

1. List three effects of medication on self-image along with the mechanisms of these effects.
2. Describe three ways an individual's role in the world may shift when they are not on medications anymore.
3. Describe three ways that a person's relationship with sources of care may be affected by deprescribing.

Gupta, Swapnil, and John Daniel Cahill. "A prescription for "deprescribing" in psychiatry." Psychiatric Services (2016): 904-907.

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Bertram P. Karon, PhD, ABPP *Changes in Psychoanalytic Theory and Technique: Learning from My Patients*

Introductory

Sigmund Freud attempted to create an integrated theory of the human personality throughout his life; but as he put parts of the theory together, new observations required him to revise it. At no time did Freud have a completed, integrated theory because it no time did he stop observing, thinking, and if of discovering. Freud said that anyone who took seriously the ideas of the unconscious, repression, resistances (which are the same as the defense mechanisms used in ordinary life), and transference was practicing psychoanalysis even if they disagreed with him in every other respect. Today psychoanalysts disagree not only with each other but also with their own earlier formulations. Our patients continuously teach us what we need to know to help them, and to help other people. Our patients continually teach us what it means to be human.

At the conclusion of this activity, participants should be able to:

1. Describe the changes in psychoanalytic theory and technique.
2. Outline how to use psychoanalytic theory and technique effectively.
3. List three ways to enhance your ability to learn from patients.

Tom Payne, Jo Allen and Tony Lavender, Hearing Voices Network groups: experiences of eight voice hearers and the connections to group processes and recovery, Psychosis (2017, 205-215).

Swapna Kongara, Chris Douglas, Brian Martindale and Alison Summers, Individual psychodynamic therapy for psychosis: a Delphi study, Psychosis (2017, 216-224).

Gulia Pavon and Jeroen Vaes, Bio-genetic vs. psycho-environmental conceptions of schizophrenia in perceiving patients in human terms, (2017, 245-253).

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Joe Keifer, PsyD, BSN, RN & Adam Rifkin, MA *Nurses as Agents of Change Using Recovery-Oriented Cognitive Therapy as an Evidence-Based Approach*

Introductory

A significant number of individuals with serious mental illness are not living the life of their choosing. Recovery-Oriented Cognitive Therapy (CT-R) provides a practical tool set to empower these individuals to pursue recovery despite the challenges that can impede progress. CT-R is an evidence-based practice focused on empowering professionals to collaborate with individuals and their families to help them actively pursue their preferred meaningful life. This presentation will focus on implications for nurses, such as using treatment teams to advocate for recovery-oriented practices, facilitating collaboration with individuals and their families (e.g. identifying interests, skills, strengths, and aspirations), and developing holistic programs that promote physical and mental health (e.g. programs that link health to meaningful life aspirations).

At the conclusion of this activity, participants should be able to:

1. Identify principles of recovery, and utilize these to develop a strategy to advocate for recovery-oriented care.
2. Identify at least 2 ways in which nurses can implement recovery-oriented practices within a treatment team to promote recovery.
3. Assess their own practice and identify areas in which recovery-oriented principles can be integrated.

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Mark Richardson, PsyD, Robin Belcher-Timme, PsyD, ABPP, Joseph Lesko, PsyD

On Some Obstinate Attempts to Recover Wholeness in Systems of Confinement

Introductory

That American jails and prisons are the new American state hospitals is a tragic truism (Gottfried & Christopher, 2017). Correctional systems must provide care to those confined within their walls, including those diagnosed with so-called serious mental illnesses (American Psychiatric Association, 2017). However, failures of integration of these structures with the experiences, potential, and needs of people caught in them are extensive and striking (Carpenter & Spruiell, 2011). Loneliness, raw feeling, and tension are ubiquitous and palpable, for both those who live and those who work in such places (Gilson, 2016). Separation and exclusion, the time-worn instruments of order (Foucault, 2006) of the Western society, are applied as blindly inside as outside. If one is seen as dangerous, even if in the midst of a psychosis or other extreme experience, they can find themselves further imprisoned within the prison (Reiter & Blair, 2015).

How in this world can we talk meaningfully about care, let alone a sense of community? The "obstinate attempt of two people to recover the wholeness of being human through the relationship between them" (Laing, 1967, p. 53), whether in the form of a passing, open-hearted conversation, or a longer-term psychotherapy, is often viewed with suspicion, or seen as futile. To create a facilitative, healing space needs a constant struggle. And yet, in this atmosphere of pervasive pain and trauma, one need not look far to find courageous people yearning for connection and understanding.

Presenters will trace the lines between tension and potential for freedom and community in a correctional system. Stories of meaningful relationship and activity, and meaning and purpose, will be

told. The influence of Leighton Whitaker (2009, 2013) in the development of camaraderie and empowerment in a residential treatment unit will be celebrated.

At the conclusion of this activity, participants should be able to:
1. Articulate the prevalence of serious mental illness and psychological trauma within the inmate and correctional staff populations in American correctional facilities.
2. Describe the environmental and relational challenges facing those interested in working together towards life, liberty, and wholeness within correctional facilities.
3. Through case presentations, discuss how some barriers to forming meaningful and productive relationships have been overcome.

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Bret J. Fimiani, PsyD *Listening to Psychosis: Bridging the Gap Between Psychotic and Non-Psychotic Experience*
Intermediate
My presentation will address the theme of this conference, "the gap between…," both in terms of the gap that characterizes the relationship between clinician and patient and in terms of the gaps we encounter in our systems of care. My point of departure is the position of the analytic clinician, not working in a silo, but instead working in tandem with other providers and in conjunction with experts by experience.

There is a fundamental divide or gap between the clinician and the person who is experiencing psychosis. What is in fact at stake when a clinician encounters a person with a system of distressing beliefs (AKA delusion)? What is the ethical responsibility of the clinician and what position might s/he assume, in the relationship, in order to create the conditions for trust? How do we navigate (or reduce?) the gap between clinician and the person experiencing psychosis so that a new type of therapeutic relation is possible? Lacan, and neo-Lacanians in particular (see W. Apollon, et al., 2002), have

provided us with a guide on how to listen to psychosis in a way that can create the possibility of a (symbolic) treatment.

However, there are shortcomings of the Lacanian approach that need to be addressed in order for clinicians to make more authentic therapeutic connections with people experiencing psychosis. I will suggest an approach that, while relying on existing Lacanian techniques (e.g., techniques developed at the "388" in Quebec City), integrates the vital role of experts by experience in order to further de-pathologize experiences that include voice hearing and distressing beliefs. The Hearing Voices Network pushes clinicians to confront biases inherent in their own training. For example, can we still speak of "treatment" without, by definition, pathologizing psychotic experiences? Or, what is the difference between so-called "collusion" (i.e., understood as getting "too close" to delusion or "illness") and, by contrast, respectful listening to psychosis with an aim of facilitating meaningful change in the life of the person in distress? I will explore these questions by way of relevant conceptual work and in conjunction with case vignettes from my work in a public community clinic in San Francisco.

At the conclusion of this activity, participants should be able to:
1. Demonstrate three key elements that may predict an effective analytical treatment of psychosis.
2. Identify two psychotic clinical presentations for which an analytically informed multidisciplinary approach may be an efficacious treatment for psychosis.
3. Describe "the structure and experience of psychosis" as it is understood in contemporary Lacanian psychoanalysis, with an emphasis on integrating the role of experts by experience in the treatment.

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Bergeron, D. (2002). The work of the dream and jouissance in the treatment of the psychotic. In R. Hughes & K.R. Malone (Eds.), After Lacan: Clinical practice and the subject of the unconscious (pp. 71-85). New York: SUNY Press.

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Carina A. Iati, PsyD & Jeannie Bass *Beyond Belief: A Humanistic Approach to Supporting Individuals with Unique or Unusual Beliefs*

Introductory

This presentation will outline a person-driven framework that can be utilized as either a group therapy intervention or within expert-by-experience led groups. In initial development the group's primary purpose was to create a safe, supportive space within a psychiatric hospital setting for individuals to openly share their unique beliefs (often labeled as "delusions") and promote a feeling of acceptance, validation and support. The secondary aim of the group was to develop a curriculum of user friendly activities and semi-structured conversations that allow for individuals to process their beliefs and build the flexibility to examine how their beliefs impact their life as well as giving individuals the space to alter their beliefs based on their personal goals and values. The group has also addressed such topics as how personal and societal beliefs are formed, how to evaluate whether a belief is helpful or hindering, when and how to safely share one's beliefs, and discussion of beliefs as a continuum as opposed to a traditional dichotomy of "normal" and "delusional".

This presentation will outline the core values of the group and describe how those values have been utilized as the cornerstone of this distinctive, shared experiential approach. Specific activities and topics as well as preliminary feedback from group members and other providers will be shared. This overview will also touch on the development and facilitation of the group as a collaboration in between a clinician and expert-by-experience.

At the conclusion of this activity, participants should be able to:

1. Name and describe the three core values of the Beyond Belief group philosophy.
2. Identify at least two activities to assist people in reflecting on and evaluating the impact of their beliefs on the quality of their lives.
3. Identify and discuss examples of how unusual/unique beliefs share a connection with a person's life story.

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., & ... Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. BMC Psychiatry, 14(1), 1-23. doi:10.1186/1471-244X-14-39

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Kevin Healey *If the Deepest, Darkest Pain You Hold Inside Could Speak - What Might it Say?*

Introductory

We keep making things more complicated than we need to. We divide the world into categories to simplify our understanding then forget that the categories exist only because we invented them.

HVN has for thirty years shown us the nonsense of regarding every person who hears voices as being "in psychosis" but we still regard voices as "the problem". This serves no one especially those who struggle. Meanwhile, that other key signifier of "psychosis" - "disconnected from reality" is no more reliable or "scientific" than a politician's #alternativefact.

Likewise, "Trauma" at least in the too-narrow, non-thinking, misleading and even harmful way we use it- is also fast becoming useless, and denies many from making sense of their experiences because "nothing that bad ever happened to me".

Voices some would categorize as "negative" are often the same voices as those called "positive". A person struggling with voices they find difficult-to-hear likely also feels powerless in other aspects of

their life. One reflects the other. If we don't yet understand then we have yet to listen enough or well enough.

Psychosis is pain: of living and struggling to make sense in a world that too often does not allow us to. Whether a person becomes traumatized has less to do with what happened than the way they are treated afterwards. Treatment often wounds us most.

Trauma means wound. A traumatized person is wounded, in pain and the darkest, most difficult-to-hear voices emerge from this pain. Psychosis is not illness but the organism fighting for its life the only way they know how.

Ultimately, what heals is not any therapy but allowing the person to find enough safety and enough agency to make sense of their experiences and find their place in the world.

It's time we learned to listen- really listen.

At the conclusion of this activity, participants should be able to:

1. Reflect upon their own life and describe if their deepest darkest pain held inside could speak, what it might say.
2. Explain how sharing relevant experience with a client or other person they support can help build a relationship with that person.
3. Discuss how listening to a client's voices may help in their recovery from trauma.

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Linklater, Renee. Decolonizing Trauma Work. Fernwood, 2014.

Burton N. Seitler, PhD *Psychoanalytic Psychotherapy of a 3 1/2 year-old Girl Diagnosed as Autistic*
Intermediate
Autism is not ordinarily considered to be a form of psychosis, and yet there are a number of similarities. For example, there is commonly a loss, or a severely disturbed form of contact with reality, particularly with important care-giving figures. Physical objects are related to with greater interest than people. In some reports, there are descriptions of a regression back to a much earlier mode of existing, not unlike what are sometimes seen in certain psychotic reactions. Moreover, where language exists, it is highly peculiar and idiosyncratic, not infrequently involving echolalic utterings. In all cases, it represents one of the greatest challenges for therapists to establish contact with someone who seems to occupy a "world of one" (hence the name), but not necessarily the world-at-large as we know it. In this presentation, I will trace my early meeting with "Didi," a 3 1/2 year old girl who was diagnosed with autism and how I utilized her own echolalia to make a very rudimentary contact with her. From these primitive beginnings, she progressed from no eye contact, to fleeting glances in my general direction, to a momentary "peek-a-boo" gaze, to mutually looking at each other; from no speech to echolalic verbalizations, to one or two words, to a series of basic communications, and finally--after considerable work--to the development of an internalized ego-albeit a primitive one; to back and forth interaction in which I ultimately became a separate object from her, and she from me, to early interactional speech. Not unlike how one works with psychosis, effective psychotherapy all comes down to the relationship.

At the conclusion of this activity, participants should be able to:
1. List 4 common features of autism and childhood psychosis.
2. Describe the general sequence involved in creating a safe space for this patient to express herself in her own way.
3. Define a psychoanalytic relational approach to working with an autistic youngster.

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Marilyn Charles, PhD, ABPP, Danielle Frank, MSW, April Stein, PhD, Sarah Winchester, MSW
Psychotic Symptoms, Psychotic Systems, and the Search for Meaning
Psychotic symptoms are often perceived as symptoms of illness needing medical intervention rather than signs of difficulty needing interpersonal attention. And yet, clinical experience and international efforts show how people can be driven mad by interpersonal and systemic failures to recognize the very real problems needing to be faced and worked through. This impasse leaves us with standards of care that are often at odds with the developmental needs of those who turn to mental health providers

for assistance. At times, diagnostic systems and other social structures are dehumanizing and destabilizing, and the exacerbation of symptoms is taken as proof of 'the problem.' From a psychoanalytic perspective, symptoms always have meanings that are told in coded form because interpersonal communication has been disrupted. From that perspective, systems that refuse to recognize such meanings are, themselves, crazy and therefore crazy-making.

In this panel, we will discuss ways in which a spectrum of psychotic and psychotic-like symptoms emerge in young adults in relation to familial and societal pressures and deficits. Illustrations will show how such symptoms can mark unrepresentable meanings, driven by various systemic issues, including that of family, institution, culture and state. Having a psychoanalytic perspective can help the clinician to hear the story being told and invite the young adult to be more respectful of their own narrative, thus building a more coherent narrative through which to build a more solid and resilient identity. Working in both college counseling centers in and therapeutic communities, it has been our experience that those who evidence psychotic symptoms are often seekers; seekers of truth, meaning, and identity. In this panel, we hope to further the ISPS mission of respectfully meeting the challenges posed by those who become marginalized and lost in relation to systems that subvert rather than support their development.

At the conclusion of this activity, participants should be able to:

1. Describe one way that medical terminology can obstruct obtaining assistance.
2. Describe one way that clinicians working in such systems can perhaps shift the system through respectful engagement.
3. Describe one way in which a psychoanalytic perspective can help an individual to recognize meanings in psychotic symptoms.

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